			1 - For State Registrar	State of	warytan	-	artment of H tificate of I		ana iv	-	giene Reg. No.	กกร	21001
	Physici	20	Decedent's Name (First, Middle, Li	ast)						2. Date of De		 	3. Time of Death
	Physici /Medio			nces	DeSand	o-Lich				June 9	9, 20	005	8:16 P M
*	Examin	er	4a. Facility Name (If not institution, gi 12909 Camellia	ve street and nun Drive	nber)		4b. City, Town, or	Location o er Spr				Montgo	
	Funeral				7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Bir (Month, Da		9 R	irthnlace (State or Foreign
	Director		578-42-0521	1□M 2□ F	74	Yrs.	Months Days	Hours	Min.	March l	9, Year)	.931 Wa	Country) (State of Foreign (Sountry) (Sountry)
	pu 🔭		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	action						10d. Inside City Limits
	faryla sho	ō											1 Yes 2 No
	28a-	rect	Maryland Mon	ntgomery	51	lver S	10f. Zip Code				10a, Citiz	zen of What (Country?
	3a or	I D	12909 Camellia	Orive			209	06				USA	
	thin 72 hours after death with the Maryland e. "Intural", or Items 23a or 28a-f show Mudical Exam not must be notified at	Funeral Director	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13. \	Vas Decedent of H Yes, specify Cuba	ispanic Orig	gin? (Spe	ecity Yes or No	- 1	14. Race - An Black, Wh	nerican Indian,
S	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 🔀 No e		☐ Yes 2 🛣 No	Specify:		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify: Wh	•
2-003p	hour tural		3 Widowed 4 Divorced 15. Decedent's E	Year or Da	ites:	16a Deced	lent's Usual Occup	ation			16h Kir	nd of Busines	s/Industry
Ċ N	in 72 n "nal	Completed	(Specify only highest gi	ade completed)	Acr E ()	(Give	kind of work done of NOT use retired	durina most	of worki	ing			y County
_	¥ 5 € ₹	Com	Elementary/Secondary (0-12)	College (1	-40r 5+)	Caf	eteria M	anage	r		Scho	ols	
and	be filed ntal Hygi od other evant, II	Be	17. Father's Name (First, Middle, Las Elmer James Bar	•						(First, Middle, Rousea		Sumame)	
<u>X</u>	ould be Mental varked o	2											
Mar	permit. Pages 1 and 2 should be it Deperment of Health and Mennal Himportant: If item 27 is marked of any injury or other traumatic even once.		19a. Informant's Name/Relationship Nathan Lichter/				g Address (Street: 9 Camell:						,
<u>ရ</u> ်	Healt Healt tam 2		20a. Method of Disposition	nasbana	20b. F	lace of Dispo	sition (Name of			Date			or Town, State
aitimor	ages and of		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Contro		State Geo:	emetery, cren rge Wash	natory or other place ington Ceme	etery		ne 14, 2005			Maryland
	oorter		21. Signature of Funeral Service Lice		1	FE	Anceled Address	ssed Facility	ins	Funeral			
מ	Per Constitution of the co		1 7ru S	Scer	lo	50	0 Univer	sity 1	Blvd	, W, Si	lver	Sprin	g,MD 20901
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that ca	used the deat	h. Do not ente	er the mode of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
ķ. F	Physician		Immediate Cause (Final disease or condition	Recta	l Cance	r							Onset and Death 2 Years
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ————————————————————————————————————	or as a conseq	uence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
'n	exec an an	Еха	resulting in death) Last	Due to (or as a conseq	uence of):							
09/90	ficate be executed p physician and is the burial-transit	cal	(d									
	certifica nding pt use as tl	Medi	IF FEMALE:										
Š O	death ce e attend ed for us	lan/M	23b. Was decedent pregnant in the past 12 months?		rth 2 🗌 Feta	Ideath 3□	Ectopic pregnancy				2	3d. Date of d Month	elivery Day Year
	the de	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregna 9□Unkno	ant at time of d wn	eath 5∟	Other (specify)						,
ŗ.	w requires that the death certif been signed by the attending should be detached for use at	y Ph	Part II. Dther significant conditions	contributing to de	ath but not res	ulting in the ur	iderlying cause give	en in Part I.		23e. Did t	obacco us	se contribute	to the cause of death?
cords,	The law requires that ate has been signed b bage 2 should be deta	ed by								10	Yes 2 <u>√</u>]No 3∏1	Probably 4 Unknown
၀ ၁	aw re	ompleted								24a. Was		24b. Were	autopsy findings available
										autor perfo	rmed?	death?	completion of cause of es 2 \sum No
NEG	ilcian: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						of Death	(Check only o			
5	Physic this c	70	1 ☐ Yes 2 No		npatient 2			4 🗀 1901		me 5X Resid			pecify)
	ding I	tion	27. Manner of Death 1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation		n, Day Year)	28b. Time of Injury	28c. Injun Work	/at <br Yes 2 □ N		28d. Describe i	now injury	y occurred	
DIVISION	Attan deat ctor: y the	ertification:	3 ☐ Suicide 6 ☐ Could not t	28e. Place	of Injury - At ho	ome, farm, stre	et, factory, office			28f. Location (S	Street and	d Number or I	Rural Route Number,
.	al or a s after il Dira	Serti	4 Homicide determined	buildin	ig, etc. (Specif	y)	,			City or Tov	vn, State))	
	hours hours uners	calC	29a. Certifier (Check only 2 Medical Exe	hysician: To the	best of my kno	wledge, death	occurred at the tin	ne, date and	d place,	and due to the	cause(s)	and manner	as stated.
	To the Hospital or Attanding Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,	fedical	опе)	and mann	or stated.	uon and/or inv	estigation, in my of		ri occurr				
,	To To Con	Σ	29b. Signature and title of certifier				29c. License	number D4588(0			e signed (Moi .ne 10 ,	nth, Day, Year) 2005
1	0		A CU	7610									
l	-		30. Name and address of person who Leon C. Hwang, I				orint) ive, Rocl	kville	e, M	D 20850)		
		te	31. Date filed (Month, Day, Year)		gistrar's Signa		AD						

			1 - For State Registrar	State of Ma	ryland /	•	artment of rtificate c			-	iene eg. No. 20	05 21002
	Physicia /Medic		Decedent's Name (First, Middle, Last EMILI	JA DI	BENS					2. Date of Dea Month JUNE	7,2005	3. Time of Death 11:15 ^{A M}
1	Examin	er	4a. Facility Name (If not institution, give National Lut		me		-	n, or Location of			4c. County of Montgo	
	Funeral Director		Social Security Number 6. Se		93	birthday) Yrs.	If Under 1 Ye Months Day	ar If Under		8. Date of Birth (Month, Dey Oct. 14	Year) 1911]	B. Birthplace (State or Foreign Country) Latvia
	Maryland -f show	tor	Usual Residence of Decedent 10a. State	mery	10c. City, To		Rockvi	lle				10d. Inside City Limits 1 X Yes 2 □ No
	with the a or 28e be noti	Direc	10e. Street and Number 9701 - Veirs	Dr.			10f. Zip Cod	20850		1	0g. Citizen of Wh	at Country?
36	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "naturel", or items 23s or 28s-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:		- 1		of Hispanic Ori Cuban, Mexicar		ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc. White
21215-0036	rithin 72 hounde. ne. han *nature. e Medical E.	Completed I	15. Decedent's Edu (Specify only highest grad	cation		(Give life.	dent's Usual Oc kind of work do DO NOT use re	ne during mos tired)	t of workin		16b. Kind of Busin	
	be filed ital Hygi d other event, I	To Be Co	12 17. Father's Name (First, Middle, Last) Mardens Kai	lens		CI	eaning	18. Moth		(First, Middle,	<u>Cleanir</u> Maiden Sumame) stenjs	ng Service
Maryland	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic	-	19a. Informant's Name/Relationship (7) Dace Pelletti								r. City or Town, St	
Baltimore,	a se sa		20a. Method of Disposition 1	Removal from State	20b. Place ceme	of Dispo	osition (Name of matory or other eek Ce	place)	D	ate	20c. Location - Ci	ity or Town, State
Balti	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Solice licens	2010			6510	g Co.	,Inc	O+ NIW	Wash.,	, DC
8760,	physician and by sician and by	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I also be a final to a market acuse. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to lo as	a consequence	te 31 (of):	s ve de	lean	A	Laile Lin	est,	Approximate Interval Batween Onset and Death I MONTH. Vears Vears L Weeks
.O. Box 6	the death certifics y the attending pl ched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 □ Yes 2 □ NO 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		⊒Ectopic pregna ⊒ Other <i>(specify</i>				23d. Date of Month	
ecords, P.	iaw requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions co	ntributing to death b	ut not resulting	g in the u	inderlying cause	given in Part I		23e. Did to		ute to the cause of death? Probably 4 Unknown
$\boldsymbol{\alpha}$	The ate ha	Completed								24a. Was a autops perform	med? pric	ere autopsy findings available or to completion of cause of ath?
Vital	ician: certific	o Be	25. Was case referred to madical examiner? 1 Yes 2 No	Hospital:	int 2□ER/	Outpatio	nt 3 DOA	Other		(Check only or	ence 6 ⊡Other	(Specify)
ion of	ding h. After fune	-	27. Menner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28t	o. Time o Injury	of 28c. I	njury at Work? 1 🗌 Yes 2 🗍	2		ow injury occurred	
Division	tel or Atters after de el Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, et	ury - At home, c. <i>(Specify)</i>	farm, st	reet, factory, offi	ice	2	28f. Location (S City or Town	treet and Number n, State)	or Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	edicai		sicien: To the best ner: On the basis of and manner sta	examination					ed at the time, d	ate and place, and	d due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	W. Ka	resh	w	7 29c. Lic	ense number	26	/	9d. Date signed (Month, Dey, Year)
X.	2(2)		30. Name and address of person who court of the state of					Or., R	ocky	/ille,N	1d.	1
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 0 2005		ar's Signature		de)			,		

			for State		State of M	-	epartment of F Certificate of		Mental Hy	giene Reg. No.		
			Registrar 1. Decedent's Name		st)				2. Date of De		7000	3. Time of Death
	Physici /Medio		FRAN	IK.	DAVIS	, 5R			Month	07	2005	2-47 M
	Examin		4a. Facility Name (If LAURE)	L REG	ONAL F	OSPITA	1	aure 1	th	4c.	County of Death	George's
	Funeral		5. Social Security Nu	mber 6.5	Sex 12 M 2□F	ge (In yrs. last birt	Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th ay, Year)	9. Birtl	hplece (State or Foreign untry)
	Director		577-20-9	100	Z M 2 L F	90	frs.		08-23	3-19	14 Sou	th Carolina
	fand ww		Usuet Residence of I	10b. County		10c. City, Town	or Location					10d. Inside City Limits
	Mary Fed	to	DC				1	Washingto	on			1 DXYes 2 ☐ No
	th the	Director	10e. Street and Num	ber			10f. Zip Code			10g. Citi	izen of What Co	untry?
	23a c	rai		1223 I	St., N.E.			20002				d States
36	s 1 and 2 should be filed within 72 hours efter death with the Maryland f Health and Mental Hygiena. If Health and Sa or 28s-f show titam 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinational be notified at	by Funeral	11. Marital Status 1 □ Never Marrie 3 □ Widowed 4		12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		Specify Yes or No to Rican, etc.))- 	Specify:	
5-0036	72 hor	Completed		15. Decedent's E y only highest gr		16a.	Decedent's Usual Occup (Give kind of work done	pation during most of wa	nrkina	16b. Ki	ind of Business/	
2121	ithin 7	nple	Elementary/Secon		Cotlege (1-4or	5+)	life. DO NOT use retired	d)	g			
2	e filed within al Hygiena. I othar than ' vant, the We	ဝိ	10t		1		Labo	orer	me (First, Middle	Maiden	Govern	nment
anc	ould be fi Mental H arkad ot atic avar	Be	17. Pathers Name (7	Edward	•			10.140011613142			Andrews	
Maryland	2 should be and Mental is marked a	ဥ	19a. Informant's Nar			19b.	Maiting Address (Street	and Number or R				Zip Code)
Ma	nd 2 alth ar		Robert	L. Davi	s - Son	98	307 Binyon (Ct., Ft.	Wash.,	MD .	20744	
Je,	as 1 a of Hea itam rotha		20a. Method of Dispo		Domewal from State	comotor	Disposition (Name of y, crematory or other plan	ce)	Date	20c. Lo	cation - City or	Town, State
Ē	Page nent c ant: if ury or		1 ⊑ Burial 2 ⊑		□Removal from State fy)		incoln Ceme	tery 6/	13/2005		Brentwo	od, MD
Baltimore,	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other 20028.		21. Signature of Fun	MIT.	Thorn	TIL	22. Name and Addres	nning Rd.	Stewart., N.E.	Wash		me 20019
			23a. Part 1. Enjer the shock, or year	e disease, or con failure. List only	plications that cause one cause on each	d the death. Do n	ot enter the mode of dyir	ng, such as cardia	c or respiratory a	irrest,		Approximate Interval Between Onset and Death
M	Physician		Immediate Cause (F	inal	ASP.	TRATIO	N PNEU	MONI	4			Oliser and Death
	/Medical Examiner		resulting in death)	· ·	Due to (or a	s a consequence of				_		SEVERAL
	T = G	ner	Sequentially list con- if any, leading to im- cause. Enter Under Cause (Disease or in	mediate lying	Due to (or a	s a consequence of		1-100	,			YEARS
	icate be executad physician and s the burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La		C	KLAL s a consequence of	FIBRILL.	AITON				,,,,,,
68760,	icate be execu physician and s the burial-tra	ai E	, , , , , , , , , , , , , , , , , , ,		HY		ENSION	/				
387	physics the	edicai		•	d	12111	27,010,7					
. Box	eath certif attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 Unknown	nonths?		e of pregnancy 2 Fetal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у		2	23d. Date of deli Month	ivery Day Year
b, P.O	ras that the d signed by the be detached	by Ph	Part II. Other signific	cant conditions	contributing to death	but not resulting in	the underlying cause give	ven in Part I.	23e. Did t	tobacco u	ise contribute to	the cause of death?
Division of Vital Records,	~= ~ ~ ~ ~				CSTE				1 🗆	Yes 2[□No 3□Pro	obably 4 Unknown
မင္မင	aw 1s b	Completed			RENAL				24a. Was	DSV	24b. Were au	topsy findings available completion of cause of
E.	Thate ate	Con		CHRON	ic OBST	RUCTIV	E PULMOH,	ARY DISE	FASE1 Yes	ormed? 2 No	death?	21 No
/ita	Physician: Th this certificate al director, pag	Be	25. Was case referre		Hospital:		O#	200	ath (Check only			
of	Phys this al dia	To	1 ☐ Yes 2 X 1 27. Manner of Death		Impai		patient 3 DOA Ott	4 🗆 (4013)(19)	Home 5 Resi 28d. Describe			cify)
on	ding I h. After funer	tion	1 Natural 2 Accident	5 Pending	28a. Date of Inj (Month, D	ay Year) Ir	ijury Woi	rk?]Yes 2□No				
/ISi	Attanding r death, actor: After oy the fune	ifica	3 Suicide	6 Could not be	28e. Place of Ir	njury - At home, far	rm, street, factory, office	-	28f. Location (Street and	d Number or Ru	ıral Route Number,
Ö	s efter	Certification;	4 Homicide		building, e	itc. (Specify)			City of 10	wn, State,		
	To tha Hospital or Attandi within 24 hours effer death. To tha Funaral Diractor: A completely fillad in by the fu	edical (of examination and	, death occurred at the tit for investigation, in my o					
	To the To the Comp	ž	29b. Signature and t	itle of certifier	1001 -	14 >	29c. Licens				e signed (Month	
			* Aled	ulNa	Jeen 1	n.D.		21294				-2005
0	p (15)				ompleted cause of	death (Item 23a) (Type, Print) RT MEAL	DEROA	D, SUIT	E 100	LAUR	EL, MD 2072
	Sta Registr		31. Date filed (Montl	-	5 Regis	trar's Signature	book					
			301	4 T 0 22	The same of the sa		-					

			For State Registrar	tate of Maryland / De	epartment of Health a Sertificate of Death		giene Reg. No. O.O.E. O.I.D.O.L.
			Decedent's Name (First, Middle, Last)			2. Date of De	ath - 3. Time of Death
	Physicia	an		•		June	6 2005 10:25 A M
	/Medic	-	MARY BOWMAN DAVIS 4a. Facility Name (If not institution, give street)	et and number)	4b. City, Town, or Location of		4c. County of Death
	Examin	er					Calvert
			Calvert County Nurs 5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Prince Freder:	4 Hrs. 8. Date of Bir	th 9. Birthplace (State or Foreign
	Funeral Director			2XF 84 Yr	Months Davs Hours	Min. (Month, Da Aug. 28	Country) 3, 1920 Philadelphia, PA
			Usual Residence of Decedent	04		71006 20	, 1,20 111220000,1121,
	land		10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
	Mary Hish	ō	MD Calvert	Prince 1	rederick		1 ☐ Yes 2 X QXNo
	the 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	Sa or		85 Hospital Drive		20678-4018		U.S.A.
	be filed within 72 hours after death with the Maryland Hygiene. 4 other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, I're Macalle Examiner must be notitled at	Funerai		Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Orig	nin? (Specify Yes or No)- 14. Race - American Indian,
	ter of	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	If Yes, specify Cuban, Mexican	, Puerro Rican, etc.)	Black, White, etc.
9	al', o	þ	3 ☐ Widowed 4 反 Divorced	If Yes, Give T Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White
21215-0036	2 ho	Completed	15. Decedent's Educati		ecedent's Usual Occupation Give kind of work done during most	of undring	16b. Kind of Business/Industry
7	7 nin 7	pie	(Specify only highest grade co	College (1-4or 5+)	fe. DO NOT use retired)	or working	
2	r tha	E	12		. Secretary		U.S. Government
0	should be filed within nd Mental Hygiene. marked other than imatic event, it a M.	BeC	17. Father's Name (First, Middle, Last)		18. Mothe	r's Name (First, Middle	, Maiden Sumame)
Maryland	td be enta ked ic ev	To B	Claude I. Bowman Sr	•	Lore	tta Whelan	
2	2 should and Men is marke		19a. Informant's Name/Relationship (Type,		failing Address (Street and Number	r or Rural Route Numb	er, City or Town, State, Zip Code)
S	V 0 - 0		Susan M. Kenny, Nei	ce 540	3 56th Ave., Ri	verdale, Ma	aryland 20737
ē,	ss 1 and 2 should of Health and Men item 27 is marke other traumatic		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place)	Date	20c. Location - City or Town, State
<u></u>	ages int of t: If i		1 N Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	Olivet Cemetery	5/10/2005	Washington, DC
Baltimore,	it. Purtme		21. Signature of Funeral Service Licensee	. Hount	22. Name and Address of Facility	Gasch's Fi	uneral Home, P.A.
Ba	permit. Pages 1 Department of h Important: If ite any injury or of 2005e.						tsville, Maryland
			23a. Part1. Enter the disease, or complicat	ions that caused the death. Do no			arrest Approximate
и			shock, or heart failure. List only one	ause on each line.	_	. /	Illesval perweell
	Physician		Immédiate Cause (Final diséase or condition resulting in death)	Hour Ke	8 piratury	andre	
	/Medical Examiner		resulting in doubly	Due to (or as a consequence of	1 01	-1. L.	Pulmoneng
	LXummor		Sequentially list conditions, b	Due to (or as a consequence of	Charc Do	Spachoc	1 monen
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence of			
	and and II-tran	can	that initiated events c resulting in death) Last	Due to (or as a consequence of			
8760,	cate be executed physician and the burial-transit	I E		220 10 (0) 23 2 0011004231100 01	•		
876	cate be ex physician the buria	dicai	d				
9		Mec	IF FEMALE:				
Вох	The law requires that the death certific ste has been signed by the attending p cage 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	o dea he at	sici	1 ☐ Yes 2 ☑ No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		
P.0	at the by the stack	hy	9 Unknown			220 Did	tobacco use contribute to the cause of death?
	gned oe de	by [Part II. Other significant conditions contri				\
Records,	w requir been si should	ed	17 Their	ers Disc	ase	''	Yes 2 No 3 Probably
00	s be	Completed				24a. Was	s an 24b. Were autopsy findings available prior to completion of cause of
H	The law cete has page 2:	Eo				perf 1 ☐ Yes	ormed? death? 2 death? 1 death?
Vital		a	25. Was case referred to medical		26. Place	of Death Check on	
>	Physician: this certific ral director,	To B	avaminar?	pital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4 Nu	rsing Home 5 Res	idence 6 ☐Other (Specify)
of				28a. Date of Injury 28b. Tir	ne of 28c. Injury at		how injury occurred
on	Attending Phir death. sctor: After thi	tion	1-ENatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inj	M 1 Yes 2	No	
İS	Attendia death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farr	n, street, factory, office	28f. Location	(Street and Number or Rural Route Number,
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A	Certification:	4 Homicide	building, etc. (Specify)		City or 10	wn, State)
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	24 h Fur etely	edicai	(Check only 2 Medical Examine one)	: On the basis of examination and and manner stated.	or investigation, in my opinion, dea	th occurred at the time	, date and place, and due to the cause(s)
	o the ithin o the omple	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)
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		Holy Cross	Hospi	ital			r Spring				gomery
Funeral Director		5. Social Security Number 579-84-6404		7. Ag	e (In yrs. last birthday) 47 Yrs.	Months Days	If Under 24 Hrs Hours Min.		/, Year)	601	nplace (State or Fore untry) York
show	'n	Usual Residence of Deceder 10a. State 10b. Co	unty		10c. City, Town or Lo	ocation					10d. Inside City Lim 1 ☐ Yes 2X
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ms 2	Funeral	11. Marital Status	OII DI	12. Was Decedent Armed Forces?	Ever in U.S. 13.		Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No-		4. Race - Amer	
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey Edith Alverta Dailey 8:00 A.M. June 18, 2005 4b. City. Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Continuum Care Sykesville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 5 Social Security Number 6. Sex Months Days 1□ M 22 F 91 215-40-6330 Yrs October 19, 1913 Maryland Usuet Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. Stete west. Mineral Keyser 1 ☐ Yes 2 No Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Route 1 Box 158 A-1 26726 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Maritel Status 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Gertrude May Hedrick Edward Jacob Sheeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack Goebel-Son-In-Law Route 1 Box 158 A-1, Keyser, West Virginia, 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 21, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland, Maryland Cumberland Crematory 2005 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home 8 East Main St., Lonaconing, Md. 21539 wa E. Enter the disease, or comparations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 100

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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filed within 72 hours after deeth with the Maryland Hyglene. ther than "naturel", or terms 23a or 23a-4 show

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Baltimore, Maryland 21215-0036

lem 27 is marked other than "naturel", or fems 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at

Physician/Medical Examiner ρ Certification: To Be Completed

Attending Physician: The law requires that the death certificate be executed certificete has been signed by the attending physician end lirector, paga 2 should be detached for use as the bunal-trensit To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner?				26. Place of D	eath (Check only one)
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3 ☐ Suicide 6 ☐ Could not to determined		nome, farm, street, fa	ctory, office		28f. Location (Street end Number or Rurel Route Number City or Town, Stete)
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my knowniner: On the besis of examinating and menner stated.	owledge, deeth occur ation end/or investiga	red at the tion, in my	ime, date end pla opinion, death oc	ice, end due to the cause(s) and manner es stated. courred et the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D30119 29d. Date signed (Month, Dey, Year) 20-05

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

habida (SINOW Mes ville 6216

State Registrar

31. Dete filed (Month, Day, Year)

32. gistrer's Signature

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2005 Year **Physician** Beatrice L. Earle 9, June 12:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) April 29,1911 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Min Months Days Hours 1 ☐ M 2 🛱 F 94 Virginia 577-03-6124 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiene. Importents if item 27 is marked other than "natural", or iteme 23a or 28a-1 show my lury or other treumatic event, the Madical Examinar must be notified at once. 10a State 1 Yes 2 No Md. Gaithersburg Directo Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Ave. 20877 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Avon Representative Cosmetics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gilbert Knupp Elnora Dundore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Leng (Daughter) 106 Ridge Road Washington Grove, Md. 20880 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State June 13, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Suitland, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home ETUS 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Meumonia /Medical Due to (or as a consequence of): Examiner Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executs.) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physicien and I be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 10 3 Probably 4 Unknown cate has been signed, pege 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 Yes 2010 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 D61817 . 12 2005 June 10

Registrar DHMH 17 Rev 1/2001

State

9901 Medical Center Dr. Rochville, Md. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

A. Registrar's Signature

Dr. Shahyar Gharacholou

31. Date filed (Month, Day, Year)
JUN 1 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death DINAO 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Alfred George Ennulat 7:55a June 8, 2005 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Cross Hospital Holy Montgomery 8. Date of Birth (Month, Day, Year) Jan. 28, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Hours 1 X M 2 □ F 055-24-2097 73 New York Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1308 Mullins Street 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Supervisor F.B.I. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Ennulat Luise Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helene E. Ennulat/ Wife 1308 Mullins Street, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 14, June 1 □Burial 2 □ Cremation 3 □ Removal from State St. John's Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Middle Village, New York 21. Signature of Funeral Service Licensee Francis Adies Collins Funeral Home Inc 500 University Elvd, W, Silver Spring, MD 20901 anes 23a. Part1. Enter the disease, or complications that call sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Acute Myocardial Infarction disease or condition resulting in death) Minutes Due to (or as a consequence of): Coronary Artery Disease 2-3 Years Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that introduced to the control of Due to (or as a consequence of) Hypertension Years that initiated events resulting in death) Last Due to (or as a consequence of): Diabete Mellitus, Type II 2 Years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☑ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural Injury 5 □ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) D05809 June 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John G. Lodmell, M.D. 2901 Olney-Sandy Spring Road, Olney, MD 208323

Registrar DHMH 17 Rev 1/2001

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Physician

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Examiner

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31. Date filed (Month, Day, Year)

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the second or
Physician

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

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After

To the Funeral Director: completely filled in by the

within 24 hours e To the Funeral (

physician

Baltimore, Maryland 21215-0036

orrant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinat must be notified at a.

32. Registrar's Signature

			For State Registre MEND#26per		-		artment of H		•	giene Reg. No.? (105	211110
			Decedent's Name (First, Midd		#1/1 LCC				2. Date of De	ath		3. Time of Death
	Physici /Medio			llmore	E	/a			Month June	Day 11, 20		2:00 a M
	Examir	er	4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or	Location of Death		4c. Cou	inty of Death	
			Elternhaus	1	7 4 //-	(- A friends d - A	Dayton	If Under 24 Hrs.	0 D-11 - (D)-	How		101
	Funeral Director		5. Social Security Number 219-54-8039	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 90		Months Days	Hours Min.	8. Date of Bir (Month, Da Dec. 2	v Year)	Cou	place (State or Foreign ntry) h Africa
	pue *		Usual Residence of Decedent 10a, State 10b, Count		10c. C	ity, Town or Lo	cation				- · · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
	sho	ō		omery		Silver	Chrine					1 ☐ Yes 2 🔀 No
	28a-1	Director	10e. Street and Number	JOMEL y		TIVEL	10f. Zip Code			10g Citizen	of What Cou	ntry?
	with		12001 Old Col	lumhia Pik	٠.		2090	1		rog. Onizon		
	eath	erai			cedent Ever in U	IS 13 1	Was Decedent of Hi		ecify Yes or No	- 14.1	USA Race - Ameri	can Indian.
36	d within 72 hours after death with the Maryland jene. Ir than "natural", or ltams 23a or 28a-f show the Medical Exact nor must be rediffed at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ XWidowed 4 □ Divorce	rried Armed F 1 Yes If Yes, G	forces? 2 ∑XN o iive		If Yes, specify Cuba 1 ☐ Yes 2 ☐ ★No	Specify:	Rican, etc.)	1	Black, White,	
21215-0036	72 hour 'natural'		15. Decede	nt's Education est grade completed,		(Give	tent's Usual Occupa	luring most of work	ing	16b. Kind o	f Business/In	ndustry
2121	e filed within II Hygiene. other than "	Completed	Elementary/Secondary (0-12)	2	(1-4or 5+)		DO NOT use retired				rical	
Maryland		o Be	17. Father's Name (First, Middle Walter Claude					18. Mother's Nam	e <i>(First, Middl</i> e, Mary Wil		name)	
ar.	shound M	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street a	and Number or Rui	al Route Numb	er, City or To	wn, State, Zij	Code)
	nd 2 alith a 27 is		Marilynne R.	Eva-Evans	/ Daugh	ter 1	2001 Colu	mbia Pike	e, Silve	er Spr	ing, MD	20904
ē,	es 1 and 2 should b of Health and Ment: I Itam 27 is marked r other traumatic		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place		Date		on - City or To	
Ë	Pages nent of I		1 Nation 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (1 State	_*	Memorial G	amleng	ne 14, 2005	Marri	otsvil	le, MD
Baltimore,	permit. Pages Department of Imp. rtant: If I any Injury or once.		21. Signature Juneral Service	Licensee	1	F:	R. Name and Address T.	s of Facility. Collins	Funeral	L Home	Inc	, MD 20901
	_		23a. Part1. Enter the disease, of	or complications that	caused the dea						spring	Approximate
	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause on	each line.	15						Interval Between Onset and Death
	/Medical- Examiner		resulting in death)	Due to	(or as a conse	quence of):						<u> </u>
9	Laminer		Sequentially list conditions,	b. Dua f	ecub	Los	Ulce					TWOUT
	sit s	iner	if any, leading to immediate Cause (Disease or injury	4 Due to	(or as a conse	querice or):						
	and and Il-tran	Exami	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):						Vees
8760,	cate be executed physician and the burial-transit	dicai E			`							•
687	ficate p phy: ss the	edic		u								
.O. Box	at the death certifi by the attending (trached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregn birth 2 Fet gnant at time of nown	al death 3	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ery Day Year
Δ.	es tha	by	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	V		he cause of death?
Vital Records,	e law has b	ompleted							24a. Was autoj perfo			opsy findings available impletion of cause of
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medic	al			, 200	26. Place of Deat	h (Check only o	one)	4 T	
	dii d	70 6	examiner?	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursing Ho	ome 🔾	ASS.	sted Li	ying Pacility
n of			27. Manner of Death 1 ANatural 5 ☐ Pend	28a. Date (Mor	of Injury nth, Day Year)	28b. Time o Injury	28c. Injun Won	at k?	28d. Lascrice	how injury oc	curred	
<u>Ö</u> .	Attending r death. sctor: Atterby the fune	atic	2 Accident inves	tigation				Yes 2 □ No				
Division	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Plac	e of Injury - At I ding, etc. (Speci	nome, farm, str ify)	eet, factory, office		28f. Location (City or To		imber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Directory to the Funeral Directory to the Funeral Directory filled in b	edical C		ing Physician: To the I Examiner: On the and mai								
	To the within 2 To the comple	Me	29b. Signature and title of certific				29c. License	number		29d. Date sig	ned (Month,	Day, Year)
	10		N. S.	XX	a M	D	na	8747		June	, 13.	2005
7	10		30. Name and address of person	n who completed car	use of death (Ite	m 23a) (Type	Print)	J, 11			CS	2005 Jumbia
			Randal F	Riese				orter	Dr 5	oite 25	0	MD 2104
	Sta	te	31. Date filed (Month, Day, Yea.	r) 2.		ature		-, [=]				100
3	Regist		JUN 15	2005	Registrar's Sign	April	S.C.					

			1 - For State of Maryland /		rtment of H			giene Reg. No.	05 2101	
П	Dhysisi		Decedent's Name (First, Middle, Last)				2. Date of De	Day	3. Time of Deat	
	Physici /Medio		John Frank Finamore				June		2005 14:45 P	М
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death	4c. Cour	nty of Death	
_	Francis		Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last U	birthday)_	Baltimo If Under 1 Year	re If Under 2		th	9. Birthplace (State or For	eign
	Funeral Director		579-38-4692 ^{18⊡M 2□F} 73	Yrs.	Months Days	Hours	Min. (Month, Da	1931 (1931)	Washington, I	DC
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loo	ation				10d. Inside City Lin	nite
	show	ក							1 ☐ Yes 2¥☐	
	28a-f	Directo	Florida Collier N 10e. Street and Number	aples	10f. Zip Code			10g. Citizen o	of What Country?	
	3e or		832 Tanbark Drive, #201		34108			USA		
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His	spanic Orig	in? (Specify Yes or No Puerto Rican, etc.)		ace - American Indian, lack, White, etc.	
8	J within 72 hours after death with the Maryland Jiene. r than "neturel", or Items 23e or 28e-f show It e Miscical Examiner must be notified at	by Fu	1 Never Married 2 Marned 12 Yes 2 No If Yes, Give 1958-60	1(Yes 2X No		T about t made in accord		cify: White	
3-003e	hours tural,		3 Widowed 4 Divorced Year or Dates:		ent's Usual Occupa	ntion		16b Kind of	Business/Industry	
2 2	in 72 n "net	Completed	(Specify only highest grade completed)	(Give ki	ind of work done d O NOT use retired)	lurina most	of working	TOD. KING OF	Dusiness/moustry	
7	d within glene. or than "	omo	Elementary/Secondary (0-12) College (1-4or 5+) 12	Owne	r			Comme	rcial Printing	
2	ba filed ital Hygie id other event, II	BeC	17. Father's Name (First, Middle, Last)				's Name (First, Middle	, Maiden Sum	ame)	
ylan		To	Louis J. Finamore				y Petrone			
Ma			19a. Informant's Name/Relationship (Type, Print) Margaret M. Finamore/ Wife				or Rural Route Number, #201, Na			
ē,	tam 27 tam 27 other tr		20a. Method of Disposition 20b. Place	of Disposi	ition (Name of atory or other place	2)	Date	20c. Location	n - City or Town, State	
Ê	Pages in it.		1 △ Buriai 2 □ Cremation 3 □ Hemoval from State		ven Cemete:	'	June 18, 2005	Silver	Spring, Maryland	
saitimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other t		21. Signature of Funeral Service Licensee	Fr.	Name and Addres	s of Facility	ins Funeral	l Home	Inc	
2 —	89588		James & Vada	50	O Univer	sity 1	Blvd, W, S:	ilver S	Spring,MD 2090	1
			23a. Part1. Byter the disease, or complications that caused to death. D shock, or heart failure. List only one cause on each line.					rrest,	Approximate Interval Between Onset and Death	1
2	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cell	Lune Co	1000	oma		3 month	25
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence Sequentially list conditions.	ce of):	1 1 000				21000	
	10/190	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	ce of):	5011500				or marks	
	outed id	Examine	if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
Ď	e exec len ar urial-t		resulting in death) Last Due to (or as a consequence	ce of):						
8/60	certificate be executed nding physicien and use as the burial-transit	dicai	d.	_						
×	ding	by Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy					234 [Date of delivery	
X D	ath ter or u	ciar	23b. Was decedent pregnant in the past 12 months? Yes 2 No		Ectopic pregnancy Other (specify)				Month Day Year	
л Э	t the c by the	hysi	9 ☐ Unknown 9 ☐ Unknown							
s S	requires that the der een signed by the a hould be detached f	by Р	Part II. Other significant conditions contributing to death but not resulting	g in the und	derlying cause give	n in Part I.		/	ontribute to the cause of death	
ecora	w requir been s should	ted					1 📝	T		
S S	S S S	Completed					24a. Was	an 24t osy ormed?	b. Were autopsy findings available prior to completion of cause death?	of of
<u> </u>	The ate						1 Yes	2□ No	1 ☐ Yes 2 ☑ No	
Vital		o Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/	Outpatient	3□ DOA Othe		of Death (Check only of sing Home 5 ☐ Resi		Other (Canada)	
0	y Phys er this eral di	!	27. Manner of Death 28a. Date of Injury 28b	b. Time of	28c. Injury	at	28d. Describe			
o	Attending Fir death. ector: After by the funer	atlo	2 Accident investigation	Injury	Work M 1□Y	r Yes 2 □ N	lo			
DIVISION		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, building, etc. (Specify)	, farm, stree	et, factory, office		28f. Location (City or To	Street and Nur wn, State)	mber or Rural Route Number,	
2	pital or urs afte arai Dir illed in						I also and do As As	- ()		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowled (Check only one) 1 ☐ Medical Exeminer: On To the basis of examination and manner stated.							
	To the within To the comple	Me			29c. License	number		29d. Date sign	ned (Month, Day, Year)	
	6		Kirka Pavio, UD		ATay	1389	46	June	12,2005	
	Far		30. Name and address of person who completed cause of death (Item 23a	a) (Type, P	rint)	10	7 11.			
			KISha Days UD Union Men	2011 CL	1 MOSPI	tal	Baltman	e, MD		
	Sta Registi		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23: 1. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Spine	NEW STATE					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2, Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:15 P M Kenneth Verne Freed 7 June 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Feb. 20, 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Year. Months XXM 2□F 87 Yrs. 214-38-0224 1918 Indiana Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show treumatic event, the Medical Examiner must be notified at Anne Arundel 1 ☐ Yes 2√∑No Maryland Annapolis Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code ò 523 Wilson Road 21401 U.S.A. or items 23a death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mentat Hygiene. ent of Health and Mentat Hygiene. ent: if item 27 is marked other than "naturel", or ite 1 XYes 2 No If Yes, Give Year or Dates 1935-56 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŒNo Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronics Specialist Electronics 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joshua Freed Lula Bell Wires ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen V. Freed/wife 523 Wilson Road Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot 2005e. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 6/13/2005 Davidsonville, MD ¹ 4 □ Donation 5 □ Other (Specify) uneral Arvy Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatura 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) Maccro /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter linearying Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last -transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 22 No 3 Probably 4 Unknown 1 Yes page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 Yes 1 ☐ Yes or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 2 10 2 1 Yes 2 ER/Outpatient 3□ DOA 1 Decinationt this 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerei Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) strar's Signature 31. Date filed (Month, Day, Year) 32 Re State 2001 Registrar

			For 1 _ State	State of M	aryland / Dep			Mental H	ygiene		
			Registrar		Ce	ertificate of	Death	1.0	Reg. No.	005	21012
н	Physic	an	Decedent's Name (First, Middle, I COLA DD ANGE C	•	- DEMENT CTT	c CDECODI	2	2. Date of 8 Month	Day	Year	3. Time of Death
	/Medi	cal	GOLA FRANCES 4a. Facility Name (If not institution, g		≥BENEDICTI	4b. City, Town, o		June	10 4c Cou	2005 unty of Death	10:30 M
	Exami	ier	Mariner Health		-		Spring	aur		ntgome	
	Funeral			Sex 7. Aç	je (In yrs. last birthda)) If Under 1 Year	If Under 24 H				place (State or Foreign
	Director		578.05.6583	1 □ M 2 🖾 F	88 Yrs.	Months Days	Hours M	Jan. 1	8, 1917	' Cart	ers_Bridge
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits
	Aarylan f show	ō		omo r si		Spring					1⊠Yes 2□No
	the A	Director	Maryland Montg 10e. Street and Number	omer y	SIIVEI	10f. Zip Code	 		10a, Citizen	of What Cour	ntry?
	3e or	0	12914 Georgia Av	enue		20906	i		U.S		,
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin?	(Specify Yes or N	io- 14. i	Race - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked othar then "neturel", or Items 23e or 28e-f show any injuty or other traumatic avant. I've Mudical Exertical to recitified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced			1 ☐ Yes 2 ☒ No	Specify:	ento Alcan, etc.)		Black, White, ecify: Whit	
5-0	72 ho netui	Completed	15. Decedent's (Specify only highest of		(Giv	edent's Usual Occup	during most of w	vorkina	16b. Kind o	of Business/In-	dustry
121	within ene.	mpl	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired	1)	,		1 .	
2	iled v Hygie Ithar t		10th 17. Father's Name (First, Middle, Las	at)	Re	staurant		ame (First, Midd	-	d Servi	Lces
Maryland	iould be filed v I Mental Hygie varked othar i	o Be	William Henry	Bryant			Lillia		Clemen		
Z	shoul nd Me mark	^L	19a. Informant's Name/Relationship		Son 19b. Mai	ling Address (Street					Code)
	s 1 and 2 should be the finance of the firm 27 is marked oother traumatic ava		Dr. Joseph A. D	eBenedicti	,	5 Zeigler	Way, S	ilver Sp	ring. M	arvlar	nd 20904
Jre,	of He of He		20a. Method of Disposition	Domeral from State	20b. Place of Disp			Date		on - City or To	
altimore,	Pages ant: If		1 ABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			coln Ceme		14/2005	Brent	wood,	Maryland
Balt	permit. Pages: Department of H Important: If its any injury or of		21. Signature of Funeral Service Lic	ensee	İ	22. Name and Addres HINES-RINA 1800 New	ss of Facility LDI FUN Hampshi	ERAL HOM	E, INC	Spring	g, MD 20904
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not en	nter the mode of dyin	g, such as cardi	ac or respiratory	arrest,	Брітпр	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		tic Bladde						Onset and Death
	/Medical		resulting in death)		a consequence of):	I cancer					
	Examiner	L	Secuentially list conditions	b MRSA of	Left Isch	ial Wound					
	ed sit	lne	Sacrentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):	_					
•	xecut and	Examine	that initiated events resulting in death) Last		Renal Fai a consequence of):	Lure			_	-	
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical E		d Osteomy	elitis of	Ischial B	one				
Box (eath certiff attending I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnancy			23d.	Date of delive	эгу
o.	it the deat by the atti- tached for	Physician/M	in the past 12 months? 1 □ Yes 2 🗷 No 9 □ Unknown	4☐ Pregnant at 9☐ Unknown		Other (specify)				Month	Day Year
۵.	es that igned b	by PI	Part II. Other significant conditions		ut not resulting in the	underlying cause give	en in Part I.	23e. Did	tobacco use c	ontribute to th	ne cause of death?
rds	w require been sig should b		Anemia of Chron	ic Disease				. 1 🗆	Yes 28No	3 Prob	ably 4 Unknown
of Vital Records,	The law reate has been	ompleted	Severe Malnutri	tion Secon	dary to B1	adder Can	cer		ormed?		psy findings available mpletion of cause of
ita	ian: rrtifica ctor, p	BeC	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only		10,103	20.40
<u>_</u>	Physician: this certific ral director,	ToE	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie	nt 2 EP/Outpatie	nt 3 DOA	er: 4🗷 Nursing	Home 5 ☐ Res	idence 6 🗆 0	Other (Specify	1)
U O		:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time of Injury	Work		28d. Describe	how injury occ	urred	
S	tan death tor: the	catl	2 Accident investigation 3 Suicide 6 Could not	he			Yes 2 □ No	201 1	(0)		
Sivislon	P S S C	ertification;	4 ☐ Homicide determine		ury - At home, farm, si c. (Specify)	reet, factory, office			wn, State)	mber or Hurai	l Route Number,
	To the Hospitel or Al within 24 hours after o To the Funeral Direc completely filled in by	edical C	29a. Certifier 1 Certifying P (Check only one)	hysicien: To the best miner: On the basis of and manner sta	examination and/or it	th occurred at the tim evestigation, in my op	e, date and place pinion, death occ	ce, and due to the curred at the time	cause(s) and date and plac	manner as stree, and due to	ated. the cause(s)
	o the	Med	29b. Signature and title of certifier		`	29c. License	number		29d. Date sig	ned (Month, I	Day, Year)
	7-0		Sama	Khani	aln	D-005	8965		June 1	11, 200)5
•	フ		30. Name and address of person who		1						
			Saima U. Khawaj	a, M.D., 1	119 Rockvi	lle Pike,	Suite	#100, Ro	ckville	, MD 2	20852
	Sta Registr		31. Date filed (Month, Day, Year) JUN 14 2	32 Registra	ar's Signature	all					
		25		N-SCHOOL STATE							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** GROVES KATHLEEN MARIE JUNE 12 2005 1413 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗙 F Days Hours Director 215-38-6487 68 1936 Maryland Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Exampler in must be notified at 1 Yes 2 No Md. Carroll Woodbine Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 21797 6715 Woodbine Road United States death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U. S. Government Security Adjudicator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Agnes Gaither Heil V. Herbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health and
Important: if item 27 is rr
any injury or other traum Gina M. Bradshaw / Daughter 6715 Woodbine Road, Woodbine, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Burtonsville Union 6/16/05 Burtonsville, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee muriel H Back P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCUV Pnysician News disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Į. in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 Yes 1 Yes Division of Vital To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 XYes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 13,2005 10051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerron MN 2073 Mancheste RJ Monchester P. Hen 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 15 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JUNE 10, 2005 2:55 P YAKOV GRINMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∏ M 2□ F Months Days Yrs. Director 70 AUG 29, UKRAINE 213-55-1091 Usual Residence of Decedent with the Manyland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at Yes 2 No MARYLAND MONTGOMERY ROCKVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12630 VEIRS MILL ROAD, #1220 20853 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after dal Hygiene. d other then "neturel", or Itam 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 ELECTRICAL ENGINEER FACTORY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ant: If Itam 27 is marked ott DAVID GRINMAN SARAH LEMSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12630 VEIRS MILL RD., #1220 ROCKVILLE, MD injuny or other to 20853 ZINAIDA GRINMAN, WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injuny or once. PARKLAWN/MENORAH GDNS 6/12/2005 ROCKVILLE, MARYLAND 21. Signature of Funeral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GARCINOMA RENAZ CELL METASTATIC YEARS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No O 9 Unknown 9 Ulnknown α. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 □ No 1 Yes 2 1 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ₺ Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 k No Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attanding F s after death. Il Director: After d in by the funera After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MARYLAND D42452 JUNE 10, Ehrlie legarporel 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) DR. CHITRA RAJAGOPAL, 18111, PRINCE PHILIP DRIVE, #327, OCNEY, MANYCAND 32. degistrar's Signature 31. Date filed (Month, Day, Year) JUN 15 2005 State Registrar

			For State	• •		nd / Depa	artmen	t of H	lealth a	and M	-		Legible	•		
			Registrar			Cei	rtificat	e or l	Death	-		Reg. No.	20N	5	211	111
	Physici	212	Decedent's Name (First, Middle								2. Date of Do Month	aath Day	Yea	r	3. Time of	
	/Medic		Bernard Donald	Gross							June	10			7:50	PM
П	Examin	er	4a. Facility Name (If not institution	, give street and num	ber)		4b. City,	Town, or	Location of	of Death		4c. (County of De	ath		
		*.	Holy Cross Hos						Spri	ng			ntgome			
	Funeral		5. Social Security Number	6. Sex 7 1 ☑ M 2 ☐ F	. Age (In yrs 88	. last birthday)	Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	ay, Year)		Count		_
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	he N	Director	MD Montgo	mery	S	ilver S	pring 10f. Zip					10a Citia	zen of What (Count	n/2	
	with a or				"		7.0									
	should be filed within 72 hours after death with the Maryland und Mental Hygiene. marked other than "natural", or liems 23e or 28e-f show marked other than "natural", or liems 23e or 28e-f show matic event, the Maryland Examination as the modified at	Funerai	15100 Interlac	hen Drive		118 12 1	209		ienanie Ori	ain? /Sna	cify Ves or N		ed Sta			
	item Item	ŭ.	11. Marital Status 1 ☐ Never Married 2√ Marri	Armed Ford	es?	0.3.	If Yes, spec	offy Cuba	n, Mexican	, Puerto I	cify Yes or No Rican, etc.)		Black, Wi			
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Maryland 21215-0036	tura	ed		t's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Kin	nd of Busines	s/Indi	ustry	
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	and 2:		Helen Gross, Sr	ouse		15100	Inte	rlac	hen I	Dr. #	909 Si	1ver	Sprin	g M	1D 209	06
<u>ნ</u>	Health Health tem 27 other tr		20a. Method of Disposition		20b.	Place of Dispo cemetery, crer					ate		cation - City of	_		
ᅙ	Pages nert of I		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ale	dean Me				5-14-	2005	01ney	z. MD			
Baltimore,	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service		out	-					s-Rina			1 1	Ioma	Inc
Ba	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		Muslint.	Hobert							Ave. S				-	
Г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car	used the dea	ath. Do not ent	er the mod	e of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betw	veen
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ŏ	eath certific attending pl	an/h	23b. Was decedent pregnant	23c. If yes, outco	me of pregr		Ectopic pr	egnancy				2	3d. Date of d			
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DIVISION	or Attend after death Director: In by the I	fle	3 ☐ Suicide 6 ☐ Could	ined 289. Place o	f Injury - At I	nome, farm, str	eet, factory	, office		2	8f. Location (Number or I	Ru <i>ral</i>	Route Numb	er.
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	spita sours neral		29a. Certifier XXCertifyin	g Physician: To the b	est of my kn	owledge, death	occurred	at the tim	ne, date an	d place, a	nd due to the	cause(s) a	and manner a	as sta	ted.	
	To the Hospital or Atta within 24 hours after de To the Funeral Direct	Medicai	(Check only 2 Medical one)	Examiner: On the bas and manne		ation and/or inv	vestigation,	in <i>m</i> y op	oinion, dea	th occurre	d at the time,	date and p	place, and du	ue to t	he cause(s)	
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)		30. Name and address of person				Print)									-
			Kshama Garg, M.	D. 17800 H	olling	gsworth	Driv	e, D	erwoo	od, M	D 208	55 <u>–</u> 13	307			
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	Registr	ar	JUN 132	005 Back	J. J.	A STORY	M. Color									

REPLACEMENT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene
1- State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 2 Reg. No. 2005 21016 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** P. M Mildred Genevieve Collins Guiffre June 2005 2:15 /Medical 4c. County of Oeath 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 17601 Roger Drive Germantown Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 4, 1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral 1 □ M 2 🕅 F Yrs 76 Maryland Director 578-34-2291 Usual Residence of Decedent the Manyland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-1 ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Germantown Director Montgomerv 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 20874 17601 Roger Drive USA 238 death Funeral ltems ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White þ 3 Widowed 4 Divorced natural', Completed I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rthen Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then any Injury or other treumatic event, If a Mang Injury or other treumatic event, If a Mang Injury or other treumatic event, If a Mang Inger. Housewife Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wilbur Collins Lvdia Vivien Coreen Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Guiffre / Daughter 13909 Carlson Farm Drive, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/13/05 4 ☐ Donation 5 ☐ Other (Specify) Gernantown Baptist Germantown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hilton Funeral Home William D. Hilton per DVR P.O. Box 86. Barnesville, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ASPIRATION PNEUMONIA Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires thet the death certificate be executed as the burial-transli that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached to 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Be Completed CHRONIC SUBDURAL HEMATOMA, ADVANCED DEMENTIA, FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an TO THRIVE, HYPERTENSION autopsy performed? 1 Yes 2 No s after deam...
ral Director: After this co..... 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Cate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Subject fell

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 13909 Carlson

MD 1 ☐ Yes 2√ No 2 Accident
3 Suicide 3/27/05 Unknown 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by determined 4 🗌 Homicide within 24 hours a To the Funaral C Home Farm Drive, Germantown, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ပ

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address

111 Penn Street Baltimore, Maryland
32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

O.C.M.E

July 25, 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** М June 10 2005 2145 Frances K. Grace /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 3, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 1 F 89 1916 216 12 0210 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show Examiner must be notified at 1 TYes 2X No MD Howard Ellicott City Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ò 8046 Old Montgomery Road 21043 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ŏ 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: Specify: þ White 3 Widowed 4 Divorced "natural", ar than "nature Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Health and Mental le markad Frank Novak Anna unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 8050 Old Montgomery Road Ellicott City, MD 21043 Frances M. Bowers/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or oti 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 6-14-2005 Elkridge, MD ¹ 4 □ Donation 5 □ Other (Specify) M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart Disease **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Respiratory Arrest Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a cunsuquent Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗆 XNo Ö (he 9 Unknown 9 Unknown Ś 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled within 24 hours a To the Funeral I 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 25b. Signature and title of certify D0051302 June 11, 2005 30. Name and address of perion who completed cause of death (Item 23a) (Type, Print) **Erosso** 3421 Benson Avenue Suite 100 Baltimore, MD 21227 Nicholas P. 31. Date filed (Month, Day Year) 32. Restrar's Signature State JUN 1 3 2005 Registrar

John F.Hutson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- State of Maryland / Department 1- State of Maryland / Department 1- State of Maryland / Department 24a per verb., G8/5-1631	nt of Health and IV 1405 Obath		ene j. №.2 Ո Ո ⊆	91010
D		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
Physici /Medic		John Franklin Hutson		June	14 20	05 1049 AM
Examin	er		, Town, or Location of Death		4c. County of Dea	
			r 1 Year If Under 24 Hrs.	D. Data of Dieth	Talba	
Funeral Director		217-36-1292 1XD M 2□ F 65 Yrs. Months	Days Hours Min.	8. Date of Birth (Month, Day, Y Jan 2 194	0 Mary	thplace (State or Foreign ountry) 11and
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yland 2 ould be filed a Mental Hygic arked other	Be	17. Father's Name (First, Middle, Last) Medford Hutson	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Irylar should be nd Menta marked matic ev	ဥ		s (Street and Number or Rura	I Route Number C	City or Town State	Zin Code)
Ma nd 2 s lith an 27 is i			73 Greensboro			2.Ip C000e)
re, s 1 ar f Hea item s		20a. Method of Disposition 20b. Place of Disposition (Na.			c. Location - City or	Town, State
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke any injury or other traumatic once.		'4 □ Donation 5 □ Other (Specify) Chesapeake Cr	emation Cn 6/	18/05 C	hester, N	faryland
Balt permit. Departr Importa			nd Address of Facility e and Helfenbe 160 Greenbsor	in Funer	al Home, 639	PA
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Vital F ician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death		110	
<u> </u>	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 Do	OA Other: 4 Nursing Hor	me 5 Residenc	e 6 □Other (Spe	cify)
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Division 9 Hospital or Attending 24 hours after death. 9 Funeral Director: After	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
To the Hospital within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	at the time, date and place, a n, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
To the within To the Comple	Me	29b. Signature and title of certifier 29	c. License number	29d.	. Date signed (Mont	h, Day, Year)
->-0		> foliapsolus	00059487		6-14-65	
		30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)				
		John Botsis 219 S Washington Street Easton	n, MD 21601			
Sta Registr		31. Date filed (Month, Day, Year) JUN 2 0 2005 42. Registrar's Signature				

			1 - For State of Maryland / Dep Registrar Ce	artment of Health and I		ene 3. No.2 0 0 5 2 0 9
	Physici	an	1. Decedent's Name (First, Middle, Last)		June 10,	Day Year 3. Time of Death
	/Medic		Marion B. Howe	T		
	Examin	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
			Wilson Health Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Gaithersburg If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign Country)
	Funeral Director		107-20-1830 1□M 2점 F 84 Yrs.	Months Days Hours Min.	(Month, Day,) April 2,	1921 New York
	<u> </u>		Usual Residence of Decedent			
	arylar	_	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1X Yes 2 ☐ No
	Ba-f	Director	Maryland Montgomery Rockville		100	g. Citizen of What Country?
	with t	٦	10e. Street and Number 199 Rollins Avenue #714	10f. Zip Code 20852		ited States
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show Josal Examinational be molfited at	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian,
"	riten	F	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No		o Rican, etc.)	Black, White, etc.
93	ral', o	l by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
21215-0036	d within 72 hours after death with the Marylan liene. I then "netural", or Items 23s or 28s-1 show the Mucical Examinations by notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	rking 16	6b. Kind of Business/Industry
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	be filed vital Hygie d other l event, III		17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	
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Maryland	shou and M s mar umat		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Ru	ıral Route Number, (City or Town, State, Zip Code)
Σ	and 2			Russell Avenue #71		
ore	T it it it			matory or other place)		Oc. Location - City or Town, State
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injuryor other traumatic ea once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Do O East Deer Park l aithersburg, MD 20	Drive 0877	rai nome
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Box	attend for us	Physician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
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of \	Physician: r this certific ral director,	P	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 Other (Specify)
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	To th To th comp	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
	4		VHRaher Berschlander	11 304115	V.	une 10,2005
	1		30. Name and address of person who completed cause of death (Item 23a) Type IT-ROBERT BIBSCHBALLY WID	Print 201 PUSSELS.	LAVENU BURG,	ne 20277
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 4 2005 Registrar's Signature	we		

			1 - State Registrar Cer	artment of Health and Mental Hygiene rtificate of Death Reg. No. 2005 21020
	Physici /Medio Examin	cal	Decedent's Name (First, Middle, Last) Oliver E. Hassell 4a. Facility Name (If not institution, give street and number)	2. Date of Death Month Day Year JUNE 6 3. Time of Death 8 - 3 Ap M 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director		Doctors Community Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 578-46-1771 1 💆 M 2 🗆 F 79 Yrs.	Lanham, Md. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York, NY
e, Maryland ZIZIS-0030	ified within 72 hours after death with the Maryland Hygiene. othar than 'natural', or Itams 23a or 28a-f show Yent, The Madical Examinar must be rediffed at	To Be Completed by Funeral Director	13. 13. 13. 13. 14. 15. 15. 15. 15. 15. 16.	10d. Inside City Limits 1X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 20720 United States Was Decedent of Hispanic Origin? (Specify Yes or No-1Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify: 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No Specify: Black Specify: Black Specify: Black Specify: Black Sistant Production Mgr Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) unk. Lillian Ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bates Dr., Bowie, MD 20720
baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injugy or othar traumatic as once.		1 LaBurial 2 Cremation 3 Hemoval from State 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MC 74	incoln 06/11/2005 Brentwood, MD Change and Address of Facility Guire Funeral Service, Inc. 00 Georgia Avenue, N.W. Wash., D.C. 20012
,00/00	es that the death certificate be executed Washington and be detached for use as the burial-transit The detached for use as the burial-transit and the detached for use as the burial-transit and the detached for use as the det	Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Interval Between Onset and Death
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on or vital Records,	ng Physician: The law requii Iter this certificate has been s ineral director, page 2 should	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No	1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No death? 1 Yes 2 No 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Place of Death (Check only one) 28. Injury at 28d. Describe how injury occurred Work?
DIVISIO	To the Hospital or Attending Physician: whith 24 hours after deals. To the Funaral Director: After this certifica completely filled in by the funeral director.	al Certification;	2 Accident 3 Suicide 4 Homicide Accident Occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	To tha Hos within 24 hr To the Fun Completely	Medical	(Check only 2 Medicel Examiner: On the basis of examination and/or invane) 29b. Signature and title of certifier	restigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 0 2003 Registrar's Signature	Print) MAIN SILSET SUITE 357, LAUREL, MS 20707

OLIVER EZEKIEL

		For State Registrar		Ce	rtificate of	Death	F	Reg. No.	100
Physicial	n	Decedent's Name (First, Middle, Last ETHEL	υ J.	H	ELLER		2. Date of Dea Month JUNE	Day 200	3. Time of Dec
/Medica Examine		4a. Facility Name (If not institution, give 2210 COLSTON DR			4b. City, Town, o	r Location of De		4c. County of	
Funeral Director		5. Social Security Number 6. Se 1060–32–3789	9x ☐ M 2X F 7. Age (In y)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year)	9. Birthplace (State or Fo Country) NEW YORK
show		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City L
culfis.	ecto	MD MONTGOME	RY	S	ILVER SPR	ING		10- 011	1X Yes 2
l Leer		2210 COLSTON DR	TVE		10f. Zip Code	20910		10g. Citizen of Wh	nat Country?
Department or health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination must be collibed at once.	by Funeral Director	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Iispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race -	- American Indian, White, etc.
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rked othe	To Be C	17. Father's Name (First, Middle, Last) AARON	SINO	OWITZ		18. Mother's N	ame (First, Middle,	Maiden Sumame)	
27 Is mai r traumai		19a. Informant's Name/Relationship (7) SANFORD HELLER -	,, ,				Rural Route Numbe		
t: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	_	natory or other plac		Date	20c. Location - C	
epartme nportan ny injury nce.	Ì	21. Signature of the rel Service Lines		22	ID CEMET	ss of Facility	ERAL HOME		NEW YORK
Medical aminer	liner	Sequentially list conditions,	Due to (or as a cons	equence of):					
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			1 - For State Registrar	State of Ma	aryland		rtificate o				Reg. No	Z 11 11 3	21022
	Physici	an	1. Decedent's Name (First, Middle, La Cleveland Hunt	•						2. Date of De Month	Da		3. Time of Death
	/Medic		4a. Facility Name (If not institution, giv			_	4b. City, Town	, or Location	on of Death	JUNE	14,	2005 c. County of Death	10747 A'''
	Examir	ier	199 TAYLOR AVENU	E -PARKING	LOT		ANNAPO					ANNE ARU	NDEL
3	Funeral Director		010 010	ex TM 2□F 7. Ag		ast birthday) O Yrs.	If Under 1 Yea Months Day		der 24 Hrs. rs Min.	8. Date of Bir (Month, Da Dec 3	th ly Year 0 1.	9. Birthr	place (State or Foreign ntry)
)	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Maryli f sho	ō	Maryland Anne A	runde1	An	napo1	is						X es 2 No
	sth with the Marylan 23a or 28e-f show	Funeral Director	10e. Street and Number 899 Marengo St	•			10f. Zip Code 214	01			10g. Ci	itizen of What Coul	ntry?
920	filed within 72 hours efter deeth with the Maryland Hygiene. yther than "natural", or Itams 23a or 28e-f show ent, the Mscheal Examination until be invilled at	b	11. Marital Status XXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Xi If Yes, Give Year or Dates:			Was Decedent o If Yes, specify Co			pecify Yes or No Rican, etc.))-	14. Race - Americ Black, White, Specify: B1	etc.
Õ	72 ho	ted	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usual Occ	supation	nost of work	rina	16b. F	Kind of Business/In	dustry
Maryland 21215-0036	d within 72 giene. ir than "nu	Completed	Elementary/Secondary (0-12) 12th	College (1-4ors	5+)		kind of work dor DO NOT use reti TUCK D				R	eico Dis	stributers
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<u>ya</u>		2	Joseph Powell			-				Graves			
Mar	12 sh h and 7 Is m		19a. Informant's Name/Relationship (Lashelle Stanb	•	or)		-					or Town, State, Zip Md . 2100	
	s 1 and 2 should of Health and Mer item 27 Is marks other traumatic	. 5	20a. Method of Disposition	ack (SISU		A CONTRACTOR OF THE PARTY OF TH	Sition (Name of			Duriir		ocation - City or To	
Baltimore,	@ ° = 5	١,	1 Surial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci	y)	Bee	Pa	rk		1	0-05		napolis	, Md.
Bal	permit. Pag Department Importent: any injury once.		21. Signature of Funeral Service Lice	1500 MO	0483	2 W	M. Ree	se &	Sons	Mort	uar	у, Р.А.	
			23a Part 1 Enter the disease or com	plications that caused	the death		er the mode of d	ying, such	as cardiac	na pol 1 : or respiratory a	S , [rrest,	Md. 2140	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Cocaine		cation							Interval Between Onset and Death
7	/Medical		resulting in death)	Due to (or as									
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<u>α</u>	ires that signed b d be deta	b	Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the u	nderlying cause	given in Pa	art I.			use contribute to the	ne cause of death?
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il Records,	The lav	Completed								auto		prior to co death?	mpletion of cause of
Vital	ysiclen: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other		th (Check only o		V	AT CCENT
of	Phys rthis ral dir	6	1 X Yes 2 □ No 27. Manner of Death	i 🗀 inpatie			IL SUIDON	* []	Nursing Ho	ome 5 Resi 28d. Describe		6 Other (Specification)	AT SCENE
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	To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	edical C		nysician: To the best niner: On the basis o and manner st	f examinat					and due to the	cause(s	s) and manner as s	
	To the within To the comple	Me	29b. Signature and title of certifier	uest	R			onse numb	er			nte signed (Month, NE 14, 20	
			30. Name and address of person who	completed cause of d	leath (Item	23а) (Туре,	Print) 111 Pe	enn S	treet	Balti	more	e, Maryla	nd 21201
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr			hart .						

Discovery Characteristics (1) Discov				For State Registrar	State of Mary		artment of I		nd Mer	, ,	ene g. No.		
As Pacify laws, or not similarity, plus manus and manuscript. HOLY CROSS HOSPITAL Social Security Names Social	ı	Physici	an	1. Decedent's Name (First, Middle, La	-					Date of Death Month	Day	Year	
Second Security Number Cases Type-10 The Security Number Cases Type-10 The Security Number Cases Type-10 The Security Number The Sec	Ì			4a. Facility Name (If not institution, given	ve street and number)					June	4c. County	of Death	.35 A ···
The Size 100 Court 100 C				5. Social Security Number 6. 579-62-1258	Sex 7. Age (In		If Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birth (Month, Day, Septemb	1946 Year)	9. Birthplace (Country)	State or Foreign
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23a Part. Effect the disease, or complications that dibbsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate from the cause (in all proposed property and the cause of	nore, iv	ages 1 and nt of Health I: If item 27 r or other tr		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 [□Removal from State	Ob. Place of Disponentery, cre-	osition (Name of matory or other pla	ace)	Date	2	Oc. Location -	City or Town, St	
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29a. Certifler (Check only one) 29a. Certifler (Check only one) 29a. Certifler (Check only one) 29b. Signature and title of certifler 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Oh M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	ō	ling Phy n. After this funeral d	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea		f 28c. Inju	her: 4 Nurs	sing Home 28d.	5 🗆 Residen	ce 6 □Othe		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Oh M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		o the Hosp ithin 24 hou o the Fune ompletely fil	Medical	(Check only 2 Medical Example)	miner: On the basis of exar	knowledge, deat πination and/or in	vestigation, in my	opinion, death	place, and hoccurred a	t the time, dat	e and place, a	and due to the ca	
Charles Oh M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	1) (1)		· cum	1	(Item 23a) (Type.	De		390	,	10/	_	
Registrar UN 1 0 2005 Resistant	K			Charles Oh M.I	0. 1500 Fores	t Glen R	load Silv	er Spr	ing, l	Marylar	nd 2091	0	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Hobbs **Physician** 11135 A M Frances June 300 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 🔀 F 85 Texas 452-18-3357 17, Director Jan. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or than "naturel", or items 23a or 28e-f show the Worldal Experience and be notified at 1 X Yes 2 ☐ No Completed by Funeral Director Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 13219 Meander Cove USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Tes 2X If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. White 3XXVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home I other t permit. Pages 1 and 2 should be filed.
Department of Health and Mantal Hyg.
Important: If item 27 is marked other, eny injury or other treumation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Burke Louise Irwin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick T. Hobbs Jr./Son 6782 Stonewall Ct. Adamstown, MD 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Gardens Cemi 6/14/05 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Murphy Funeral Home 21. Signature of Funeral Service Licensee 4510 Wilson Blvd. ek C. Macer 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician pr CARCE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality for as a nonsequence of h Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ф 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Pomoner 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☐ No this . Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated. within 2 29d. Date signed (Month. Day, Year) 29c License number 29b. Signature and title of certifier D4415 June 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, masyland 7 Locks IGH BELOW MO 1061 31. Date filed (Month, Day, Year) State JUN 1 0 2005 Registrar

Charles Robert 05-04158	Hammond, Jr. pleas amend item#23a	e Type or Pri 1,27, per Me . () State of M	nt in Blac	k/89	elible Ink.	Ensure Allealth and M	II Copies	Are L	egible.	
crn	1 - State Registrer	Claic of IVI	arytaria / L		ificate of L		, ,			
	Decedent's Name (First, Middle,	Last)					2. Date of Dea		'U05	3. Time of Death
Physician	Charles Rob	ert Hammon	d. Jr.				Month June	$\overset{\scriptscriptstyleDay}{1}\!\overset{\scriptscriptstyleDay}{8}$	$2\overset{Year}{O}\overset{f}{O}$ 5	11:20 A M
/Medical Examiner	4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death			County of Death	
Examiner	533 Baltimore B	oulevard, #	109		Westmin	nster			Carrol1	
Funeral			ge (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h / Year)	9. Birthp	lace (State or Foreign
Director	219-66-3937	1⊠M 2□F	41	Yrs.	July 5		Jan 11,	1964		land
¥) B *	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ntion				1	0d. Inside City Limits
Maryle r sho		ud ale								1. Yes 2 □ No
vith the Mar tor 28s-f at the notified	Maryland Frede:	LICK	rred	lerio	10f. Zip Code			10a Citiza	en of What Cour	atry?
within 72 hours after death with the Maryland ene. Then "natural", or items 23a or 28a-f show the Wolfest Examiner must be notified at more than the motified at more than 10 the contract or the motified at more than 10 the contract or the motified at more than 10 the contract or the motified at more than 10 the contract or the contract of the contr		o. #				1				,.
of ther death v ritems 23s timer must	433 Megan Stree	12. Was Decedent	Ever in U.S.	13. Wa	21771 as Decedent of Hi	spanic Origin? (Sp.	ecify Yes or No-		J.S.A. 4. Race - Americ	an Indian,
Fur	1 X Never Married 2 ☐ Marrie	Armed Forces	? No	1		n, Mexican, Puerto	Rican, etc.)		Black, White,	
Ours ours d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		11	∃Yes 2∭X No	Specify:		S	Specify: Blac	K
21215-0036 ed within 72 hours after dea ygiene. for then "natural", or items it, tre Modical Examinet m to tre Modical Examinet m Completed by Funer	15. Decedent's (Specify only highest	s Education grade completed)	16a.	. Deceder	nt's Usual Occupa	ation luring most of work	ina	16b. Kind	d of Business/Inc	dustry
mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DC	NOT use retired,)		0	4	
Col	12	acti	<u> </u>	FI	nisher	10 Mothada Name	(First Middle		ncrete	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiens in natural; or any Injury or other traumette avant, tra Moderal Examples. To Be Completed by F	17. Father's Name (First, Middle, L.		C-a			18. Mother's Name			umame)	
ryla nould d Men narke	Charles Robe			Mailia	Address (Ctreat	Bernett			T Cana 7'-	0-4-1
Mal 12 st h and 7 is n traun			1		· ·	and Number or Run				
Healt ther ther	Deloris Hammond 20a. Method of Disposition	- Sister				Box 386,	New Wind		Maryla ation - City or To	
Baltimore, semil. Pages 1 ar Jemil. Pages 1 ar Jepan II ar Jepan II ar Jepan II il il il il il il il il il il il il il	1 XBurial 2 Cremation				ion (Name of tory or other place					
Itime intent	4 Donation 5 Other (Special Signature of Fune al Service Le		Simpso		TNOCIST	Cemetery	6/24/05	Mt.	Airy,	Maryland
Dal Depa Impo	21. Signators of Fulled a Service	2611)			esworth	P.A., Ft	ınera	1 Home	
	23a. Part1. Enter the disease, or c	complications that caused	d the death. Do r	264	01 Ridge	Road	amascus,	_{est} Mar	yland	2087,2 te
(2/32-0-2	shock, or heart failure. List o Immediate Cause (Final	nly one cause on each li	ine.			,,	or respiratory and	001,		Interval Between Onset and Death
Physician / /Medical	disease or condition resulting in death)				vascular	Disease				
Examiner		Due to (or as	a consequence	OI).						
5	Sequentially list conditions, lary, leading to innectiate cause. Enter Underlying	b. Due to (or as	в оспвиривнов	of):						-
executed n and lial-transit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
O, executed an and rial-transit	resulting in death) Last	Due to (or as	a consequence	of):						
Box 68760 death certificate be eath certificate be eath or use as the buri		d.								
P.O. Box 6876 nat the death certificate be d by the attending physici letached for use as the bu Physician/Medical										
OX h cer endin	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 □E	ctopic pregnancy			23	d. Date of delive	*
O. B ne deat the att hed for	in the past 12 months?	4☐ Pregnant a 9☐ Unknown			ther (specify)				Month	Day Year
P.O. that the de by the detached	9 Unknown								TM.	
be be be	Part II. Other significant condition	s contributing to death b	out not resulting in	n the unde	erlying cause give	n in Part I.		2.	,	e cause of death?
w require the should be sh							1 🗆 Y	es 2.	No 3 Proba	ably 4 Unknown
Reco							24a. Was a	SV.	prior to con	osy findings available
Yital Record ysician: The law requir is certificate has been s director, page 2 should To Be Completed							1. Yes	med? 2 □ No	death?	2□ No
Vital Filiple included The certificate rector, page	25. Was case referred to medical examiner?					26. Place of Death	(Check only on			
Of \Physical Physical directions of the control of	Yes 2□No	Hospital:			3 DOA Othe	4 Nursing no				at scene
Division c trail or Attanding P rs after death. al Director: Attant led in by the fumera Certification;	27. Manner of Death 1 Natural 5 Pending		iry Year) 28b. T	Time of njury	28c. Injury Work		28d. Describe ho	ow injury o	occurred	
isio ittandi death. ctor: A the fi	2 Accident investigated and Suicide 6 Could not	ot be				'es 2□No	006 Landing (C)		No.	G. 4. M
or Al or Al or Al or Al or Al in by	4 Homicide determin	286. Place of In	ury - At home, fa c. <i>(Specify)</i>	rm, stree	t, factory, office		City or Town	n, State)	Number or Rurai	Houte Number,
Division To the Hospital or Attance within 24 hours after death To the Funeral Director: completely filled in by the	29a, Certifier 1 ☐ Certifying	Physicien: To the best	of my knowledge	doath	accuract at the time	a data and place	and due to the or	220/2) 22	nd	atod.
tha Hospl tthin 24 hou tha Funer orpletely till	(Check only 2 Medical E.	xaminer: On the basis o and manner st	f examination and	d/or inves	stigation, in my op	inion, death occurr	ed at the time, d	ate and pl	face, and due to	the cause(s)
To tha Complet	29b. Signature and title of certifier				29c. License		2	9d. Date s	signed (Month, L	Day, Year)
F 3 F 8	tru she	14-00	> KIN			CME			ne 19, 2	
	30 Name and address of person w	ho completed cause of a	leath (Item 23a)	Type D-	int)					
	30. Name and address of person w	veenberg	17,12	·ypa, rill	111 Penr	n Street	Baltimo	ore,	Marylan	d 21201
State	31 Date filed (Month Day Year)	32 Registr	ar's Signature	4						
Registrar	JUN 2 4	2005	w H	Syst	w					

			State of Maryland / De State of Maryland / De 23a per Dr., G844	partment of Health and Mealth 24,05 lbb ath	fental Hygie Reg	ene . No
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Lavinia Margaret Haller		June 17,	2005 Year 3. Time of Death / 10:30 AM M
	Examir		4a. Facility Name (If not institution, give street and number) 17 East Third Street	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
	Funeral Director		5. Social Security Number 220−16−2933 6. Sex 1 □ M 2 1 F 84 1 Prs	Months Days Hours Min	8. Date of Birth June 6,	9. Birthplace (State or Foreign Maryland
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Maryland Frederick Freder			10d. Inside City Limits iX□Yes 2 □ No
	3a or 28	I Director	10e. Street and Number 17 East Third Street	10f. Zip Code 21701	10g.	Citizen of What Country? U.S.A.
036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show disal Evantrat Frust Ee Colling at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within ane. than *	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of work b. DO NOT use retired) Sales/Clothing	ing 16l	Retail
and 2	should be filed nd Mental Hygid marked other imatic event, L	To Be C	17. Father's Name (First, Middle, Last) Roland M. Ebberts	18. Mother's Name	First, Middle, Mai	den Sumame)
Mary	12 sh th and 7 is m traum	-		illing Address (Street and Number or Rura East Third Street		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other ti once.		cemetery, o	position (Name of rematory or other place) ivet Cemetery June 20		c. Location - City or Town, State
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service License: MO0255	^{22.} Keeney and Basfor 106 East Church St.	rd PA Fund Freder:	eral Home ick, MD 21701
The state of the s	Priysician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	enter the mode of dying, such as cardiac of the first such as cardiac of t	or respiratory arrest,	Approximate Interval Between Onset and Death
68760,	Medical Examiner bhysicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, Lauring to immodrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	, Alzheimer Type		
P.O. Box 68	death certif e attending ed for use as	Physician/Med		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	The law requires that the de- ste has been signed by the a page 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 17No 3 Probably 4 Unknown
Il Records,		Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 Tho
f Vital	Physician: The this certificate had director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	26. Place of Death		6 ☐Other (Specify)
ion of	utending Phy death. ctor: After thi y the funeral o		27. Mann of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 2	28d. Describe how in	
Division	al or Attend s after death il Director: , id in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: within 24 hours after death of the Funeral Director: After this certific completely filled in by the funeral director,	Medicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause and at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier Costlete	29c. License number MD 0045	54G J	Date signed (Month, Day, Year) June 18, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Typ	Print) 4/N, Mar Rot St	Frodo.	June 18, 2005
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	the second	1 000	10 1111

State Unpend Item 23a Registrar AMENDED IDE, 6,	/13/05, LDB PEOR	erinca.	e of Beath	tas	Res	g. No.	O 12	0.11.	~ .
1. Decedent's Name (First, Middle, Last)	Neil	Jack			2. Date of Death Month JUNE		Year)5	3. Time of 1906	Death P M
4a. Facility Name (If not institution, give street			Town, or Location			4c. County	of Death		
5. Social Security Number 6. Sex 12/4 70 - 4396	7. Age (In yrs. last bin		TIMORE CIT 1 Year If Under Days Hours		8. Date of Birth (Month, Day,		Cour	-	
Usual Residence of Decedent	<i>T /</i>				Dec.4	1957	Nev	V Jer	sey
10a. State 10b. County	10c. City, Town						1	0d. Inside Ci	•
MD	Da	1+1 MC				- 07:	111111111111111111111111111111111111111		2 🗆 N
10e. Street and Number 5126	ton Avan	1	21215	-	10	g. Citizen of \	what Cour	ntry ?	
11 Marital Status 12. W	as Decedent Ever in U.S.	13. Was Dece	dent of Hispanic Ori	gin? (Spec	ify Yes or No-			can Indian,	
A District Annual Annual All	med Forces? ☐ Yes 2 ☐ No Yes Give	If Yes, spe	cify Cuban, Mexicar 2 No Specify:	n, Puerto P	ican, etc.)	Specifi	ck, White,	etc.	
	Yes, Give 1975 ear or Dates: 1977						5/0	ck	
15. Decedent's Education (Specify only highest grade com	pleted)	Decedent's Usu (Give kind of wo life. DO NOT u	al Occupation ork done during mos se retired)	t of workin	g 16	3b. Kind of B	usiness/ln	dustry	
Elementary/Secondary (0-12) Co	bllege (1-4or 5+)	Press	Man]	Dry	Cle	anir	10
17. Father's Name (First, Middle, Last)	1000		18. Mothe	er's Name	(First, Middle, Ma	aiden duman	7e)	- 114	J
	irray		AL	ce,	Mak	e_De	.5h.	elds	
19a. Informant's Name/Relationship (Type, Pr			(Street and Number	an ye		191	State, Zip	Code)	12
20a. Method of Disposition		Disposition (Na.	THE OF Y	Ve, I	ederals	c. Location	Lity or To	wn, State	00
1 ☐ Burial 2 🗹 Cremation 3 ☐ Remov. 3 ☐ Donation 5 ☐ Other (Specify)	al from State	y, crematory or c	other place)	6/13	3/05 0	0.10/0	1	2 11 7)
21. Signature of Funeral Service Licensee	IVIIC S	22. Name ar	eMation and Address of Facility Funer Vashing	y 1 1+	Me. P. A.	ampr	ing c	1 1012	,
Janelle Ca	Henry	SIUV	Vashing	TON 5	ti Cam	bride	e, N	10.21	613
23a. Part. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do n	ot enter the mod	le of dying, such as	cardiac or	respiratory arres	t,		Approximate Interval Bety	ween
Immediate Cause (Final disease or condition	lcohol and nar	cotic i	ntoxicati	on				Onset and I	Jeath
resulting in death)	Due to (or as a consequence of	of):							
Sequentially list conditions, if any, leading to immediate cause Effer Underlying	Due to (or as a consequence of	of):							
Cause (Disease or injury that initiated events c									
	Due to (or as a consequence of	of):							
d									
IF FEMALE: 230 If y	es, outcome of pregnancy						1		
in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death	3 □Ectopic po 5 □ Other (sp				Moi	e of delive nth	•	'ear
9 Unknown 9E	Unknown								
Part II. Other significant conditions contributi	ng to death but not resulting in	the underlying o	ause given in Part I.		23e. Did toba	cco use contr	ribute to th	e cause of de	eath?
					1 Tes	2 🗆 No	3 Prob	abiy 4 □U	nknow
					24a. Was an autopsy	1 0	rior to cor	osy findings a npletion of ca	available
					performe	No 1	eath? Yes	2□ No	_
25. Was case referred to medical examiner?	II:		Other	,	Check only one)	×.		CCENT	D.
1 X☐ Yes 2 ☐ No 28a 2. No 28a 2. Manner of Death 28a	1 ☐ Inpatient 2 ☐ ER/Out Date of Injury 28b. T		8c. Injury at Work?		e 5 Residence id. Describe how		er <i>(Specif</i> y ed) SCENI unk	
1 Natural 5 Pending 6-	4-05, Day Year) 6:0	nd p ^M	1 Tyes 2 X	No					
3 Suicide 6 X Could not be determined 286	Place of Injury - At home, far building, etc. (Specify)		, office	28	f. Location (Stree City or Town, S	et and Numbe State) 5126	or Bura.	Route Numb	oer, A
f	ound at home			I B	altimore	e, Mary	y1and		
(Check only 2 Medical Examiner: O	To the best of my knowledge, in the basis of examination and ind manner stated.								
29b. Signature and title of certifier	~	290	c. License number OCME			. Date signed			
Theolen U.	Findrews		OCME			JUNE	5, 20	005	
30. Name and address of person who complete	ed cause of ath (Item 23a) (Penn Str	eet	Raltimo	ce Mar	rv1 on	a 2120)1
THEYOORE MIKING		111	TCITI DCT.		TOTAL CHILD	ي الما	- y cui	u 2120	, IL

Registrar

Sta

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached.

			State of Maryland / Dep	ertificate of Death		0000
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Death	2. Date of Dea	ath 3. Time of Death
	Physicia	an	Ahmed Koshin		Month	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	June 8,	2005 2:30 P M
Н	LAdilliii	C!	18 Tynewick Court	Silver Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)			h 9. Birtholace (State or Foreign
	Director		215-47-9647 ¹ X ^M ^{2□} F 73 Yrs.	Months Days Hours Min	Jan. 1.	1932 Somalia
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	f sho	ō				1 Tx Yes 2 □ No
	the t	Director	MD Montgomery Silver 10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	3a or		18 Tynewick Court	20906	τ	Jnited States
	death	Funerai		. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	- 14. Race - American Indian,
9	hours after death with the Maryland tural; or Itams 23a or 28a-f show al Examiner must be netitied at	/Fu	1 Never Married 2 Married 1 Yes 2√ No	1 ☐ Yes 2 ☐ No Specify:	no nican, etc.)	Black, White, etc. Specify: African
	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	•••		
5	"nat	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NDT use retired)	orking	16b. Kind of Business/Industry
12	filed within 72 Hygiene. othar than "nai ent, Ine Modic	E C	Elementary/Secondary (0-12) College (1-4or 5+)	gious Leader		Religious
2	Hygothar othar	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle,	Maiden Sumame)
<u>la</u>	should be ind Mental i marked c	To B	Guled Koshin	Shu-ubo	o Kahie	
Maryland 21215-0036	2 should have and have is maintained.			ing Address (Street and Number or R		
	and 2 ealth n 27 i				-	er Spring, MD 20906
ore	Pages 1 nent of Ho int: If itan			osition (Name of ematory or other place)	Date	20c. Location - City or Town, State
Ē	. Pag tment tant: jury c		`4 □Donation 5 □Other (Specify) George Wa	shington Cem Jun		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural, or thams 28a or 28a-1 show any injury or other traumatic event, the Modical Examiner must be notified at once.					ldi Funeral Home Inc ilver Spring MD 20904
	SI (I		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	c or respiratory ar	rest, Approximate Interval Between
	Physician -		Immediate Cause (Final disease or condition	cardiovascul	an dis	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	Lxamme		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	ped usit	Examine	cause. Enter Underlying Cause (Disease or injury			
	al-tra	xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8/60	death certificate be executed e attending physician and ad for use as the burial-transit	dical	d			
99	tificat ig phy as th	ledi				
ROX	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
n	b death	sicia	1 Yes 2 No	Other (specify)		Month Day Year
J.	res that the de igned by the a be detached to	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	and at time and a second in Road I	220 Dielto	shape was contribute to the course of death?
15,	The law requires that the te has been signed by thoage 2 should be detached	ρ	Part it. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute to the cause of death?
ö	w require been si should t	Completed			-	/1
Hecords,	The law ate has t page 2 s	mpi			24a. Was a autop: perfor	sy prior to completion of cause of
					1□ Yes	2 XNo 1 Yes 2 XNo
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatie	Other	ath (Check only or	
Ö		$\vdash \downarrow$	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	-	lence 6 Other (Specify) ow injury occurred
0	c 55	atio	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
UIVISION	Atta er de: recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (S City or Town	Street and Number or Rural Route Number,
5	ital of	Cer	-			
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the tr	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place ovestigation, in my opinion, death occ	e, and due to the c urred at the time, d	cause(s) and manner as stated. date and place, and due to the cause(s)
	o tha	Mec	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
r.	1		Daticia Tomsko May, Mil	D51916		Tune 9, 2005
			30, Name and address of person who completed cause of death (Item 23a) (Type	, Print)/	e 10 /	11/ 14.5
			Patricia Tomsko Nay, 1119 Rocki	Frint). Pike, B-100	1, Kock	VIIIe, MD 20852
	Sta	te ar	31. Date filed (Month, Day, Year) Registrar's Signature	relas	, , ,	,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** June Guy Wilson Kirby 200 // /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington County Hospital Hagerstown 1 General Months Days Hours Min. Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs. Director 217-09-2760 June 28, 1917 Mary Land Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐XNo Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 16102 Cloverton Lane 21795 Funera 12. Was Decedent Ever in U.S. Armed Forces?

XXYes 2 No
11 Yes, Give
Year or Dates:

1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after all Hygiene "natural", or ite 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 1945 þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Brakeman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Is importent: if item 27 is meriany injury or other 7 Be 12 should be fi and Mental H is marked of James William Kirby Ella Frances Barrow ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16102 Cloverton In. Williemsport, Maryland of Disposition (Name of Date 20c. Location - City or Town, State Betty M. Kirby - Wife 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XX urial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park June 15,2005 Williamsport, Maryland 21. Signature of Funeral S Osborne Apuner silv Home, P.A. 425 S. Conococheague St. Williamsport, MD Approximate Int - 1 Between Ouset and Deut 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirations, or head failure. List only one cause on a ch line. Immediate Cause (Final Priysician CLUI disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown ٥ signed t d be deta 23e. Did tobacco use contribute to the cause of death? Part H. Other significant conditions contributing to death but portesulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mapner of Sath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending s efter dec. ai Director: Afr 1 ☐ Yes 2 ☐ No investigation in 24 hour.
the Funeral Director filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signatu 29c. License number latora State Registrar

•	-	For State Registrar		State	of Ma	aryland / D	epa Cer	rtment of H	ealth and Death		giene2 (Reg. No.)5	2	} !
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he M 28a-f	ecto	10e. Street and Number				101 K		Springet	LSDUITY I	wp.	10g. Citizen of W	hat Coun		Λ.
3s or	io	2100 Wall	ace	Street				1740	02		USA	1121 004	,.	
if e, INITI yial INITIAL STATES STATES of and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. Other traumatic event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married	2X XMarri	Armer	Forces?	Ever in U.S.	If	Vas Decedent of H Yes, specify Cuba	n, Mexican, Puei	Specify Yes or No rto Rican, etc.)		- Americ , White,	an Indian, etc.	
urs af	þ	3 Widowed 4	_	If Yes, Year o	Give K or Dates:	858 <u>a</u> 55	1	☐ Yes 2X No	Specify:		Specify:	Whi	te	
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Hygie thert		17. Father's Name (First	. Middle,	Last)					18. Mother's Na	me (First, Middle,	, Maiden Surname)		
d be d be d be d be d be d be d be d be	o Be	Solomon K		,					Clara	Kornblu	+			
shoul nd Me mark	2	19a. Informant's Name/I		nip (Type, Print)		19b.		g Address (Street	end Number or R			State, Zip	Code)	
2 255-		Audrey H.	Kne	е	Wife		21	00 Wallad	e St.	York, P	A 174	02		
of Hear	i	20a. Method of Disposition		3 X Removal fr	om State	cemeter	у, сгеп	sition (Name of natory or other place		Date	20c. Location - 0	City or To	wn, State	
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Dattimore, permit. Pages 1 an Department of Heal important: if item 2 eny injury or other		21. Signatur of Juneral	Service	серее	-	2005	22	Name and Address Geiple F	'uneral	Home, In	c.			
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OT VITAL P Physician: Th this certificate ral director, pag	o Be	25. Was case referred to examiner?	o medical	Hospital:		□ EB/O		Oth	0.0	ath (Check only		- (C		
Phys r this oral di	\vdash	1 Yes 2 No 27. Manner of Death	50	28a. D	ate of Inju Month, Da	ent 2 ER/Ou ry 28b.]	ime of	28c. Injur	4 Ki Nursing		dence 6 Othe		/)	
Attending Firdeath. ector: After by the funer	atlor	1 XNatural 5: 2 ☐ Accident	☐ Pendin investiç	9	viontn, Da	y Year) II	njury		k? Yes 2 ⊡No					
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 6	Could determ	ined 200. P	lace of Injuiding, et	ury - At home, fa c. (Specify)	rm, stre	eet, factory, office		28f. Location (City or To	Street and Number wn, State)	r or Rura	l Route Number,	,
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ithin 2 o the	Mec	29b. Signature and title	of certifie		namer st	2		29c. Licens	e number	- 1	29d. Date signed	(Month,	Day, Year)	
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wO.		30. Name and address	of person	who completed	cause of c	death (Item 23a) (Туре.	Print)	33/1	·	ch B.	/	7/000	111
20					21 /	no 5	5	95 1-1	n Bno	Section Con	ch 3.	ton.	~ m	7
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			1 - For State Registrar	State of Marylan		artment <i>tificate</i>			ind Me	-	giene Reg. No.	0000	21020
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Earl Robert Lowry 4a. Facility Name (If not institution, give st Shady Grove Advent:			4b. City, To		ocation of		Date of De Month	Day 1, 2, 4c.	y Year 005 County of Dea ntgomer	
	Funeral Director		5. Social Security Number 5. Security Number 5. Security Number 5. Sex 5. Security Number	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	Date of Bir (Month, Da			thplace (State or Foreign country) California
	he Maryland 28a-f show cullied at	Director	10a. State 10b. County Maryland Montgomer		y, Town or Lo	cation	nde				10a Citi	izen of What Co	10d. Inside City Limits 1 Yes 2 No
	th with t 23a or 2 ust be n		7629 Miller Fall Ro	ad		2085				, \t	•	ed Stat	•
980	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show to Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Amped Forces? 1 Ayes 2 No If Yes, Give Year or Dates: WWI		Vas Deceder f Yes, specify I Pes 25		panic Orig , Mexican, Specify:	in? (Speci , Puerto Ri	fy Yes or No can, etc.))=	14. Race - Ame Black, Whit Specify Whi	te, etc.
21215-0036	d within 72 ho giene. Ir than "natur Ir e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. I	lent's Usual kind of work DO NDT use 1remen	done du retired)	ring most	-			ind of Business	
and	d be filed intal Hygid ed other c avant, II	Be	17. Father's Name (First, Middle, Last) Trueman James Lowr	У			1			^{First, Middle,} Saunde		Sumame)	
Maryland	nd 2 should be a lith and Mental I 27 is marked o r traumatic ava	To	19a. Informant's Name/Relationship (Тур Jean S. Loughery/	e, Print)			Street an	id Number	r or Rural F	Route Numbe	er, City o	nr Town, State, 20855	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injuryor apper traumatic avant, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Stratue of Lineral Service License	moval from State For		OIN Name and	er place) Address	of Facility	Šimp!	4, 200 le Tri	5 Br bute		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death of cause on each line. Due to (or as a consequence)	Do not ent							·	Approximate Interval Between Onset and Death
8760,	rate be executed by special and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Fine time raying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)									
.O. Box 68	The law requires that the death certifics the has been signed by the attending pt bage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic preg Other (spec					2	23d. Date of de Month	livery Day Year
s, P	w requires that been signed by should be deta	by	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the ur	nderlying cau	se given	in Part I.			obacco u Yes 2[o the cause of death?
Vital Record	(0 ==	Completed								1 Tes	nsy med? 2 No	prior to death?	utopsy findings available completion of cause of
of	ding Physician: 1 h. After this certifical funeral director, p	tion; To Be	27. Manner of Death 1 Natural 5 Pending	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other: :. Injury a Work?	4 □ Nur	sing Home	5 Residue Describe	dence 6	6 Other (Spe y occurred	cify)
Division	Hospital or Attanding 14 hours after death. Funaral Diractor: Afte tely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre		-			Location (S City or Tox			ural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai (29a. Certifier (Check only one) Certifying Physical Exemination)	cian: To the best of my known: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at restigation, in	the time,	, date and nion, death	place, and	d due to the at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
)	To tha within 2	Mec	29b. Signature and title of certifier			29c. l	icense r	number 08 L	17		29d. Dal	e signed (Monti	h, Day, Year)
	771		30. Name and address of person who com		23a) (Type,	Print) Dav	id N	v. K1	ein,	MD 990	01 M	edical	Center Dr.
•	Sta Regist		Rockville, MD 20850 31. Date filed (Month, Day, Year) JUN 1 4 200	32 Registrar's Signal	ture Am	ules							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1000 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** LESHIN SKY JUNE 13 5750 A M ESTHER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTONN NORTHWEST HUSFITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. March 17, 1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 M 2 F 89 Yrs. New York Director 117-03-7830 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at a. . 1 X Yes 2 □ No Owings Mills Maryland Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 4730 Atrium Court, Apt. 481 U. S. A. 21117 Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or flee any Injury or other traumetic event 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service New York Transit Authority 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sara Teitelman Isadore Geltzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9105 Cranford Drive, Potomac, Maryland 20854 Melvyn Leshinsky - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Olney, Maryland 6/17/2005 Judean Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 23a. Part1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1091 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascula disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner art enoselestic Sequentially list conditions, any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last discus Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death ģ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate ! 1 Yes 2 No 1 🗆 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Xinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2XNo 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059736 Duton m-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WATSON M.D HOSP (TAL OLD LOURT PEBURAH NORTHWEST 5401 31. Date filed (Month, Day, Year)
JUN 15 2005 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Dav **Physician** June 9,. Catherine Rose Lockwood 2005 7:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner Laurel Regional Hospital Laurel Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 25, 1909 5 Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 F Months Days Hours Min. 95 579-62-0412 Yrs. Director Virginia Usual Residence of Decedent tha Maryland 10c. City. Town or Location 10b County 10d. Inside City Limits 10a State orient: in item 27 le marked other than "neturel", or Items 23a or 28a-f show injury or other treumatic event, the Medical Examiner must be notified at 8. 1 XYes 2 ☐ No Director Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7515 F Weather-Worn Way 21046 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 2 should ba filed within 72 hours after on and Mental Hygiene. I e markad other than "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Shirley Clara Belle Brady ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an Item 27 le Lois Ann Bernas/ Daughter 7515 F Weather-Worn Way, Columbia, MD 21046 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of He
Important: If Iten
any injury or oth June 13, 20c. Location - City or Town, State 2005 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery Washington, DC Francis Address Cornins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Furgeral Service Licensee illia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician Ischemic Cardiomyopathy 1 Week /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease 1 Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit Septicemia 1 Week Due to (or as a consequence of): Box 68760 pe Pericardial Effusion Physician/Medical 1 Week IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Dther (specify) P.0. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Atrial Fibrillation, Renal Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? ⊉Ū No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 X Inpatient 2 EP/Outpatient 3 DDA Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) ٩ 1 ☐ Yes 2 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeref [29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatine and title of certifier TTENDING 00057216 TUNE 09, 2005

State Registrar

31. Date filed (Month, Day, Year) JUN 13 2005



PHYSILIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VAN DUSEN RD LAUREZ, MD 20707

			1 - For State Regist	trar		State	of Maryla		-			ealth a		lental H	ygien Reg. N	200	15	21	03	1
	Physici	an		nt's Name (First, Midd	e, Last)									2. Date of D		ay	Year	3. Time	of Deat	h
	/Medic			ginia		1.		Lock						June		2005		1:50	a	М
	Examin	er		Name (If not institutio			mber)		4			Location			4	c. County o				
				22 Soward			7 Amo //p ur	n last hist	oface) I	If Under		ingto		0 Data at 5	li ah			mery		
ı	Funeral Director		020-0	D7-3196 dence of Decedent	6. Sex 1 □	м 21⊡ ғ	7. Age (In yr			/onths	Days	Hours	Min.	8. Date of E (Month, I Sept.	30,	^{r)} 1920	Mas	place (State intry) Sachu	sett	ign S
	land ow		10a. State	10b. County			10c. (City, Town	or Locat	tion								10d. Inside	City Lim	nits
	Mary I sh	ţō	Mary]	land	Mont	gomer	у	J	Kens	ingt	on							1 🗀 Ye	es 21	No
	h the	irec	10e. Street	and Number						10f. Zip	Code				10g. C	itizen of W	nat Cou	intry?		
	23a c	by Funeral Director	114	422 Soward	Dri	ve				2	2089	5					U	SA		
	ams	ner	11. Marital	Status			edent Ever in orces?		13. Was	s Deced es, spec	ent of Hi	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	10-		- Amen	can Indian,		
36	or It	γFι	_	ver Married 2 ☐ Mar dowed 4 ☐ Divorced	1	1 X Yes If Yes, Gi Year or D	orces? 2 Now ive WW:	II		Yes 2		Specify:				Specify:				
Ö	hour tural	d be	3 22 4416	15. Deceder			Jates:	162 [Deceden	t'e Heus	1 Occupa	ation			16h	Kind of Bus	inocc/lr	adueto.		
5	in 72 na r	olete		(Specify only highe		completed)		1 (Give kini life. DO	d of wor	k done c	lurina mos	t of work	ing		ional			tes	
212	filed within 72 hours after death with the Maryland Hygiene. yhar than "natural", or Itams 23a or 28a-f show ant, the Madical Examinar must be incitified at	Completed	Elementa	ary/Secondary (0-12) 12		College (1-4or 5+)	1	Budg	et A	Anal	yst				Healt				
ਰੂ	e filec Il Hyg otha vant.	BeC	17. Father's	s Name (First, Middle,	Last)							18. Mothe	er's Nam	e (First, Midd	le, Maide	n Sumame)		-	
Jar	Aenta Aenta rkad tic a	To E	Jos	seph Woods								Eme	line	Sween	ey					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23a or 28a-f show among injury or other traumatic avant. The Madical Examinational is notified all ance.			nant's Name/Relations L Henry/ D					_					thany	-					
re,	S 1 al			d of Disposition				. Place of D	Dispositio	on (Nam	ne of	e)		Date	20c.	Location - C	ity or T	own, State		
Ë	Page In the Page			urial 2 Cremation onation 5 Other (S		emoval from	State Ar	lingto	n Nat	tiona	1 Cen	etery	Ju 2	ly 7, 005	Arl	.ingto	n,	Virgi	nia	
Baltimore,	permit. Departn Importa any inju		21. Signatu	ure of up ral Service	Licen	6 Kr	onlo		Fra 500	neig Uni	d Addres	section sity	ins Blvd	Funera , W, S	l Ho	me In	c ing	, MD	2090)1
			23a. Part1	Enter the disease.	compli	cations that	caused the de	ath. Do no										Approxim	ate	
	Pnysician		Immediate	Cause (Final	only on		each line. Static											Onset an	d Death	
	/Medical		disease or resulting in		a		(or as a cons			ar c	Jane	2 T					-	3 Yea	ars	
è	Examiner		Cognostial	hy list conditions																
	= .= q	ner	cause. En	ly list conditions, ling to immediate ter Underlying	,		(or as a cons	equence of):											
	ate be executed hysician and the burial-transit	Examiner	that initiate	d events death) Last	c		,		,											
760,	oe exection a		resutting in	deality East		Due to	(or as a cons	equence of):											
∞	physic physic s the b	edical			d	l														_
9 ×	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Me	IF FEMALE		2:	3c. If ves. ou	tcome of preg	nancy								004 D-1-	-6 -4-15-			
Box	atten for u	Physiclan/M	in the	decedent pregnant past 12 months?		1 🗆 Live	birth 2 Fe	tal death		topic pre					1	23d. Date Mont		Day	Year	
o.	at the de by the a tached	ysi		'es 2□No Inknown		9□ Unkn	own				- //									
α.	res that igned b	by Pł	Part II. Oth	er significant conditi	ons con	tributing to a	leath but not re	esulting in t	the unde	erlying ca	ause give	n in Part I		23e. Did	tobacco	use contrib	ute to t	he cause o	f death?	
Records,	quires in sig uld bi	q pe	Conc	gestive Hea	art	Failuı	ce, Ane	mia						1 🗆	Yes :	2 □ No 3	☐ Pro	bably 4X	Unkno	wn
00	sw requir s been si s should I	Completed												24a. Wa		24b. W	ere auto	opsy finding	s availa	ble
	ysician: The lav is certificate has director, page 2	mo		·	-									aut per 1 ☐ Yes	opsy formed?	de	ath?	mpletion oi 2□ No	cause	Ж
Viital		e)		use referred to medica	1							26. Place	of Deat	Check only		0				
>	nysic lis ce direc	To B	examin 1 🗌 Ye	er? s 2 X No	Н	ospital: 1 🔲	Inpatient 2	☐ ER/Outp	atient	3□ DO	A Cthe	er: 4 🗆 Nu	irsing Ho	me 5% Re	sidence	6 Other	(Speci	fy)		
0	Attending Physician: r death. actor: After this certific. by the funeral director,		27. Manner		na	28a. Date (Mor	of Injury th, Day Year)	28b. Tin	me of ury	21	Bc. Injury Work			28d. Describe						
Sio	endil eath. or: A the fu	catle	2 🗆 Ac	cident invest	gation					М	101	/es 2 □	No							
Division of		Certification;	3 □ Su 4 □ Ho	datam		28e. Płace build	e of Injury - At ing, etc. (Spec	home, farm cify)	n, street,	, factory	, office			28f. Location City or T			or Run	al Route Nu	ımber,	
	To the Hospital or within 24 hours afte To tha Funaral Dii completely filled in	edical (29a. Certifi (Checi one)	ier 1.	ng Phys Examin	er: On the b	e best of my k basis of examination er stated.	nowledge, on and/	death oc or invest	curred a	at the tim in my op	e, date an inion, dea	d place, th occuri	and due to the	e cause(e, date ar	s) and mani nd place, an	ner as s d due t	stated. o the cause	o(s)	
	To the within 2 To tha complet	Me	29b. Signa	ture and title of certifie	ır					29c	. License	number			29d. D	ate signed (Month,	Day, Year)		
ŀ	1			Land 1	7	1	00				D359	96			J	une l	0, 2	2005		
	10		30. Name a	and address of person	who co	mpleted cau	se of death (It	em 23a) (T	ype, Prir	nt)										
				nda M. Bur				, , ,		,	Blvc	d, We	st,	#400,	Whea	ton,	MD 2	20902		
• · · ·	Sta Registr		31. Date fil	ed (Month, Day, Year, JUN 13	200	15	Registrar's Sig	nature	book	le le										

State of Maryland / Department of Health and Mental Hygiene

			Certif	icate of l	Death		Reg. No.	0	1 7 7 7
Physician	Decedent's Name (First, Middle, Last)					2. Date of Dec Month	Dey	Yeer	ime of Death
/Medical	Margaret E. Lochne				b. City, Town, or L	June_			00 AM
Examiner	4e Fecility Neme (If not institution, give str. Northampton Manor				Frederic	k	F	rederio	
Funeral Director	5. Social Security Number 6. Sex 1 □ N	7. Age (In yrs. A		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Feb. 22	th y, Year) 2,1921 M	9. Birthplace (S Country) [aryland	
7 - 200	Usuel Residence of Decedent 10a, State 10b, County	10c City	, Town or Location	on				10d. fns	side City Limi
e a se			Frede					10	Yes 201
85 E	Maryland Frederick 10e. Street and Number		1	10f. Zip Code			10g. Citizen of W	het Country?	
sa or	9628 Liberty Road			2170			United S		
nd Mental Hygiene. merked other than "natural", or tems 23a or 28e-f ehow umetic event, the Medical Exerciper must be notified at To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 24 No If Yes, Give Yeer or Dates:		Decedent of H is, specify Cuba Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Black Specify:	American Ind K, White, etc. White	
e get	15. Decedent's Educe	tion	16a. Decedent	's Usual Occup	ation during most of world	ina	16b. Kind of Bus	siness/Industry	
ygiene. ner than "natural", o nt, the Medical Exan Completed by	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired maker	dining most of work	y	Own I	Home	
Gien.	8	1272	поше	maker		45° - 4 4° 4-44			
and Mental Hy merked oth- numetic event To Be (Tohn H Tome				Daisy E		, Maiden Surname		
umer T	19a. Informant's Name/Relationship (Type	, Print)			and Number or Ru)
27 le	Judith Burrier / D.	aughter			Rd., Fr	ederick			
Department of Health and Menta important: If Item 27 Is marked any Injury or other traumatic a suce.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	lace of Disposition emetery, cremators the aven M	on (Name of ory or other place Iemorial	Garden	Date 6/14/05	20c. Location - 0		
artma ortan Injur	21. Signature of Funeral Service Licensee		22. Na	ame and Addre	ss of Facility S	tauffer	Funeral	home	
Depa any la pnce	V=1 2 8	1			sumtown				702
	28a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the death	n. Do not enter th	ne mode of dyin	g, such as cardiac	or respiratory a	rrest,	Appre	oximate val Between
hysician /Medical	Immediate Cause (Final disease or condition resulting in deeth) a		hosin or as e consequence or c Re						t and Death
ding physicien end sa as the bunal-transit VM edical Examiner		Due to (or	r as e consequer r as a consequen	nce of):					
for u			ultina in the conde	duing gourge six	on in Bart I	23h Did	tobacco use con	tribute to the c	ause of de
d by the ettending latached for use a Physician/M	Part II. Other significant conditions contri			nying cause giv	en in Part I.		Yes 2□No		
cate has been signed by the ettending page 2 should be detached for use Completed by Physician/N	Coronary ar	nellety					an autopsy ormed?	24b. Were au available completi of death?	prior to on of cause
, F & E						10	Yes 20No	1 ☐ Yes	2 🗷 No
cartificate irector, per	25. Was case referred to medical				26. Place of Dea	th (Check only o	one)		
S D	1 Yes 2LINO	spital: 1 Inpatient 2 Inpatient 2 (Month, Dey Year)	28b. Time of	3□ DOA Oth	er: 4 12 Nursing H		dence 6 Othe		
tune to the	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)	Injury		Yes 2□No				
can be the state of the state o	3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specify	ome, ferm, street,	, factory, office		28f. Location (City or To	Street and Numbe wn, Stete)	er or Rural Rout	e Number,
ST DO O		cian: To the best of my known: On the basis of examinate and manner stated.	wledge, death oc tion end/or invest	curred at the tir tigetion, in my o	ne, date end place pinion, death occu	, and due to the red et the time,	cause(s) end mai date and place, a	nner es steted. and due to the c	ause(s)
Fun tely	NAME OF THE PARTY	SING INGINION STATEO.		29c. Licens	e number		29d. Date signed	(Month, Day, 1	rear)
thin 24 ho the Fun mpletely	29h Signature and title of certifier								
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29b. Signature and title of certifier	the mi	\mathcal{D} .	MDD05	4636		June 11,	2005	
within 24 ho To the Furn completely I	29b. Signature and title of certifier 30. Name end address of person who come Syed Haque, M.D.	1	23e) (Type Prin	nt)	-	7	June 11,	2005	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 6-10-05 Amend#26.PerPhys.PCC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** June 2005 4:50 AM Sallie Louise Lvtle /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 20960 Colton Point Road Colton Point Saint Marys | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 9 / 0 3 / 1 9 1 5 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2√2 F 160-14-4766 89 Yrs. Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Prince Georges Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17202 Loblolly Court 20607 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Black ð 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Meter Maid City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elisha Howerton Anne Royster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaquatha H. McKay/Sister 17202 Loblolly Ct., Accokeek, MD 20607

Date 20c. Location - City or Town, S 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Glenwood Mem. Gar.06/11/05 Bromall, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Home 814 Franklin Street, Alexandria, VA22314 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in failure. List only one cause on each line. Interval Between Onset and Death (Final Sud

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

with the Marylend

death .

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

or Attending Physician: completely filled in by the funeral After Certification death. after death To the Hospital o within 24 hours af To the Funeral D

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene, important: If Item 27 is marked other than "natural", or Ite any injury or other treumatic event, the Modical Exertanons.		1 → Burial 2 □ Cremation 1 → 1 □ Donation 5 □ Other (S) 21. Signature of Funeral Service
Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or shock, or hear failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)
Physician: The law requires that the death certificete be executed this certificete has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	to Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1

Due to (or as a consequence of) Failure nditions Due to (or as a consequence of): nmediate rlying nest TUP MU9 ast Due to (or a consequence f) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death t pregnant 3 Ectopic pregnancy months? 4☐Pregnant at time of death 5 Other (specify) No

9 Unknown ficant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

3 DOA

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an performed? Yes 2 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No I ☐ Yes

Dav

Year

Other: 4 Nursing Home to the North American Control of Mother (Specify) Assisted Liv 28d. Describe how injury occurred Injury at Work? 1 ☐ Yes 2 ☐ No

Ct. Leonardtown, MD 20650

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) 22650 Cedar Lane

7 31. Date filed (Month, Day, Year) JUN 1 0 2005

State

Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

hysicia /Medica al er	Jam 4a. Facility Name (If n Holy Cro 5. Social Security Num	ot institution, g	Fran		Min	. 1			June	_	Day Year	121110	
neral ector	er	4a. Facility Name (If n	ot institution, g								6.	2005	5:30a
neral ector			ee Hoe		inibor)	1.10	4b. City	, Town, or	Location of D			4c. County of Dea	
or			DO HOD	pital			S	i 1ver	Sprin	p-		Montgom	erv
				. Sex	7. Age (In yrs	s. last birthday		r 1 Year	If Under 24	Hrs. 8. Date of	Birth Day, Yea	9. Bir	rthplace (State or Foreig
	 -	224 60 58		103 M 2□ F	80	Yrs.		,0	110010		-		WashingtonI
	+	Usual Residence of D 10a. State 1	ecedent 10b. County		10c. C	City, Town or L	ocation				-		10d. Inside City Limits
	5		Montgo	metv		lver Sp							1 Yes 2 No
	5			шеку	311	rver sp		. 0. 1.			10	05: (110 : 0	
i		10e. Street and Numb			_		107. 2	p Code			10g. 0	Citizen of What C	ountry?
•	era l	9727 Mount	Pisga		309 edent Ever in	110 12	Mac Deci		903	? (Specify Yes or	. No	USA 14. Race - Ame	edean Indian
by Funeral	١	11. Marital Status1 ☐ Never Married3 ☐ Widowed 4 		Armed F	orces? 2 No ive	0.3.	If Yes, spe	ocify Cubar	Specify:	uerto Rican, etc.	140-	Black, Whi	
	ted		5. Decedent's	Education grade completed))	16a. Dece	edent's Usi	al Occupa	tion uring most of	working	16b.	Kind of Business	/Industry
1	اق	Elementary/Second			(1-4or 5+)	life.	DONOI	ise retired)	uring most of	HOIKING			
	Completed	12						lerk				U.S. P	ost Office
	Be	17. Father's Name (Fig.	irst, Middle, La	ist)					18. Mother's	Name (First, Mid	ldle, Maide	en Sumame)	
	0	James R.	Murphy						Mar	, Benjam	in		
		19a. Informant's Nam	e/Relationship	(Type, Print)								y or Town, State, .	
		Annette M		ny / Wife					sgah Ro				ng, MD 2090
		20a. Method of Dispos 1 2 urial 2 0		☐ Removat from	State	Place of Disp cemetery, cre	matory or	other place	9)	Date	20c.	Location - City or	Town, State
		`4 □Donation 5			Ga	te of	Heave	n	6,	/9/2005	Si	ilver Sp	ring
		23a. Part1. Enter the shock, or heart f Immediate Cause (Fir disease or condition resulting in death)		a. Anox:	caused the dealeach line. ic Ence (or as a conse	ath. Do not er	1800 Iter the mo	New I	lampsh:	ire Ave	<u>Silve</u>	i Funera er Spring	Approximate Interval Between Onset and Death
	Examiner	Sequentially list condi- discountially list condi- cause. Enter Underly Cause (Disease or inju- that initiated events resulting in death) Las	ury	Due to	iratory (or as a conse ration (or as a conse	quence of):	t						
		IF FEMALE: 23b. Was decedent print the past 12 mc	onths?	23c. If yes, ou	tcome of pregr	nancy al death 3[⊒Ectopic p					23d. Date of del Month	livery Day Year
	ڄَ	9 Unknown											
2		Coronary				مر	underlying	cause give	n in Part I.				o the cause of death?
	Completed					Our					itopsy erformed?	prior to death?	utopsy findings available completion of cause of
	20	25. Was case referred examiner?		Hamitali						Death (Check on	ly one)		
	Ceruncauon: 10	1 Yes 2 No. 27. Manner of Death 1 X atural 2 \sum Accident	5 Pending investigat	28a. Date (Mon		28b. Time of Injury		28c. Injury Work	4 L Nursin			6 ☐Other (Specury occurred	cify)
Clark	2010	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	288. Place	e of Injury - At h ing, etc. (Spec	nome, farm, st	reet, factor	y, office		28f. Location City or	n (Street a Town, Sta	and Number or Ru te)	ural Route Number,
		29a. Certifier	Certifying I	eminer: On the b	e best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurred vestigation	at the time	e, date and pl nion, death o	ace, and due to t courred at the tim	he cause(ne, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	edica	(Check only 2[one)											
	Medical	Check only 2	e of certifier	^	100	(1)	29	c. License	number		29d. D	ate signed (Monti	h, Day, Year)

			1 _ For State	State o	f Marylar	-				1ental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle,	l act)		Ce	rtificate c	or Death	<u> </u>		Reg. No.	Ans	121020
	Physici	an	Carlito Rivera		_					2. Date of De Month	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution,				4b Ciby Town	n, or Location	of Dooth	June	11	2005	1947 M
	Examir	ier	Montgomery Gene		_		01ne		or Death			ounty of Death	
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye		r 24 Hrs.	8. Date of Bird		ontgome	
	Director		572-99-8421	1 X M 2□F	49	Yrs.	Months Da	ys Hours	Min.	8. Date of Birl (Month, Da 10/14/	y, Yeer)	Coun	lace (State or Foreign try) lipines
	D.		Usual Residence of Decedent							10/14/	1999	FILLE	<u> </u>
	arylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					11	0d. Inside City Limits
	8e-1 s	cto		Georges	Hya	ttsvil	1e						1 X Yes 2 □ No
	or 2	Director	10e. Street and Number				10f. Zip Cod	le			10g. Citize	n of What Coun	try?
	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show Iteal Examiner must be invilled at		10920 Bond Road				20783					ed State	es
	er de Items	Funeral	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Or Suban, Mexical	igin? (Spen, Puerto	ecify Yes or No- Rican, etc.)	- 14	Race - America Black, White, e	an Indian, etc.
36	rs aft	by F	1 ☐ Never Married 2 🕅 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Giv Year or D	Θ		1□Yes 2∏Xi	No Specify:	:		S	pecify: Asi	
Ş	ture		15. Decedent's			16a Decer	dent's Usual Oc	cupation					
15	in 72	Completed	(Specify only highest	grade completed)	4 5 1	(Give	kind of work do DO NOT use rel	ne durina mos	st of worki	ing	16D. King	of Business/Ind	lustry
212	d with	Eo	Elementary/Secondary (0-12)	College (1	-40r 5+)	Whar	ehouse	Worker			Who1	lesaler	
b	othe othe	a	17. Father's Name (First, Middle, La	ast)					er's Name	(First, Middle,			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of the Marylan Hygiene. Department of the Marylan Hygiene. Department of the Marylan Hygiene. Department of the Marylan Hygiene. Department of the Marylan Hygiene.	To B	Hilarion Mandoc	doc, Sr				Vict	toria	Rivera	ı		
ar	and halls ma	Ė	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Stre	et and Numbe	er or Rura	/ Route Numbe	r, City or T	own, State, Zip	Code)
Σ	and 2 salth n 27 I		Alicia Mandocdoc	- Wife		10920	Bond Re	d Hyatt	tsvil	le, MD	20783	3	
Baltimore,	L Se le		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	Pomoval from	20b. P	Place of Dispo	sition (Name of natory or other p			ate		tion - City or Tov	wn, State
Ē	Pag ment ent: I ury q		`4 □ Donation 5 □ Other (Spe			Linco	1n Crem	natory	06/18	8/2005	Brent	wood, M	D
ä	epart epart port ny inj		21. Signature of Funeral Service Li	censee		22 H-i	Name and Add	dress of Facilit	ty	al Home	T		
	₫ O E 8 0		Nanny A.	Veraen	C.	11	800 New	Hamps!	hire	Ave Si	lver :	Spring,	MD 20904
О			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that canly one cause on e	aused the death ach line.	h. Do not ente	er the mode of o	tying, such as	cardiac o	r respiratory ar	rest,	T	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mu	Lhok	iNi	بدزوح						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq								
		<u></u>	Sequentially list conditions,	b									
	ted Isit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence ot):							
•	xecu and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):		_					
68760,	ficate be executed physician and s the burial-transit	alE			,	,							
687		edical		d									
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregna						234	. Date of deliver	
m	death a atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		nth 2 ∏Fetel ant at time of de		Ectopic pregnar Other (specify)				230		y Day Year
P.0	t the by the ache	hys	9 🗆 Unknown	9□ Unkno	wn								
ις.	The law requires that the death certi te has been signed by the attending bage 2 should be detached for use a	by P	Part II. Other significant conditions	s contributing to de	ath but not resu	ulting in the un	derlying cause	given in Part I.		23e. Did to	bacco use	contribute to the	cause of death?
Records,	w require been sig should b									1 🗆 Y	95 2 N	lo 3 ☐ Proba	bly 4 Unknown
၁၁၈	law re	plet								24a. Was a		4b. Were autops	sy findings available
ř	The lavate has	Completed							-	autops	ned?	prior to com	pletion of cause of
Viital	ysicien: The is certificate h director, page	Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only on	e)	1V Yes 2	!□ No
	Attending Physicien: r death. ector: After this certific. by the funeral director.	2	1 XYes 2 No	Hospital: 1 🗆 Ir	patient 2 🔀	ER/Outpatient	3 DOA	Other: 4 Nui	rsing Hom	ne 5 Reside	ence 6 🗆	Other (Specify)	
Division of	ding P h. After tl funera		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury	28c. In		2	8d. Describe ho	ow injury oc		struck
<u>S</u>	Attendi death. ctor: A y the fu	catl	2 Accident investigat	0 110	1005	19.05		□Yes 2 💢	No S	as two	11	et veh	icles
\geq	or Atl	Certification;	3 Suicide 6 Could not 4 Homicide determine	ad 256. Flace	of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory, offic	0		City or Town	reet and No	umber or Rural I	4
	urs al			.,		stre	et		- 5	COUVE CA	اردورا	too i	1 Schooler
	Hosp Hot Fune Telly fi	edical	29a. Certifier 1 Certifying Check only 2 Medical Ex	Physician: To the laminer: On the ba	sis of examinat	wledge, death	occurred at the	time, date and	d place, a	nd due to the ca	ause(s) and	manner as stat	ed.
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Med	29b. Signature and title of certifier	and mann	er stated.								
	F 3 F 8		and this of certifier	6.	01	00°		nse number CME		2	,	gned (Month, Da	,
•	5	į	100 ld	con	-101	Keh i	2				June	, 12, 2	005
			30. Name and address of person wh	Completed cause	of death Item	23a) (Type, F	111 Pe	nn Str	eet	Baltimo	ore, N	Maryland	1 21201
	Stat	e	31. Date filed (Month, Day, Year)	32 Ae	gistrar's Signat	IAT IM						J	
	Registra			2005	ever &	1. 16/00	WELL .						

			State of Marylar	-		of Death	-	giene Reg. No.2	05 2	101.0
Physic		Decedent's Name (First, Middle, Last) Anwar Kishy	var Mir	za			2. Date of Dec Month 6 / 1 0 /	Dav	Year	Time of Death 1:35pm
/Medi) Exami		4a. Facility Name (If not institution, give str 9605 Reach Rd.				4b. City, Town, or Potomac	Location of Death	4c. County		
Funeral Director		5. Social Security Number 6. Sex 1 1 1 1	7. Age (In yrs. 81	. last birthday) Yrs.	If Under 1 Ye Months Da	ear If Under 24 Hrs	8. Date of Birt			(State or Foreign
f show	5	Usual Residence of Decedent 10a. State 10b. County Md • Montgomes		ity, Town or Loc	eation					nside City Limits ☐ Yes 2 ☑ No
th with the Merylar 23e or 28e-f show	Funeral Director	10e. Street and Number 9605 Reach Rd.	. у 10	Comac	10f. Zip Cod			10g. Citizen of V Pakist	What Country?	
JZO us after dea il', or items	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:			of Hispanic Origin? (Scuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)		ce - American Inc ck, White, etc. v: Asian	
Maryiand 21213-0020 of 2 should be filed within 72 hours after death with the Meryland ith end Mentel Hyglene. It's marked other then "natural", or items 23e or 28e-f show traumetic event, the Medical Exercites must be notified at	Be Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion ompleted) College (1-4or 5+)	(Give I life. D	ent's Usual Ockind of work do NOT use re	cupation one during most of wo tired)	rking	16b. Kind of Bi	usiness/Industry	'
re, Maryland 2 s 1 and 2 should be filed Health end Mentel Hygi tem 27 is marked other other traumatic avant, I	To Be Co	17. Father's Name (First, Middle, Last) Sheikh Niazali		nous	CMITE	18. Mother's Na	me <i>(First, Middl</i> e, nisa N		ne)	
Mary od 2 shou th end M tre mar treument	-	19a. Informant's Name/Relationship (Types Perveen Rana/ da	·			eet and Number or R				*)
0 ĕ°∓ ≥6		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Place of Dispos cemetery, crem	ition (Name or atory or other	place)	Date	20c. Location -	City or Town, S	
permit. Peges 1 and Department of Health Important: If item 27 any Injury or other to once.		21. Sonature of Funeral Service Licensee	Mater		Name and Ad	ery dress of Facility Un nnedy St.		l Mort	uary	
Physician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the deat cause on each line.	th. Do not ente	r the mode of	dying, such as cardia	or respiratory ar	rest,	Inter	roximate val Between et and Death
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	Sepsis Due to (c	or as a consequ	uence of):				4	days
executed n and el-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	or as a consequ	iahōa ol).		_			
artificate be executed ing physician and e es the buriel-transit		Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	or as a consequ	ence of):					
v requires that the death certifuctions is the attending should be deteched for use a.	Completed by Physiclan/N	Part II. Other significant conditions contril	outing to death but not res			given in Part I.		obecco use cor ′es 2□ No		
w requires the speed signed should be d	eleted by	0037742					24a. Was a perfor	an autopsy med?	available	ion of cause
n: The law icete hes b								es 2⊠No		2□ No
hysiciar this certif	To Be	1 162 24 NO		ER/Outpatient	SEI DON	Other: 4 Nursing F	ath (Check only or lome 5 Resid	ence 6 □Othe		
To the Hospital or Attending Physician: The law requires ti within 24 Hours efter death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director. page 2 should be	Certification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specit		M 1	njury at Vork? ☐ Yes 2 ☐ No ce	28d. Describe h 28f. Location (S City or Tow	treet and Numb		te Number,
e Hospital 124 hours e e Funeral I letely filled	edical Ce	29a. Certifier (Check only one) 12 Certifying Physici 2 Medical Examiner	an: To the best of my kno : On the basis of examina and manner stated.	owledge, death tion and/or inve	occurred at the estigation, in m	time, date and place y opinion, death occu	, and due to the c rred at the time, c	ause(s) and ma late and place, a	nner as stated. and due to the c	ause(s)
To the To the Comple	Me		ponto	MD	6	15 4 9		99d. Date signed プレルと		Year) 2005
		30. Name and address of person who comp Christine Lepo				nter Dr,	Rockvil	le,Md.	20850	
Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa					•		

Please Type or Print in Black adelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6,2005 **Physician** June 3:00p M Steve Moreno /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 13539 Georgia Avenue Apt.2 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace (State or Foreign $N \cdot Y \cdot N \cdot Y$ 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6/29/1990 **Funeral** 1**X** M 2 □ F 14 Yrs. Director 052-78-7782 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Silver Spring Montgomery 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 13539 Georgia Avenue Apt.2 20906 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any fillury optier traumatic event. The Medical Examinations. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Dominican Rep. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Student Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Rosa Mayra Cuello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906Rosa Mayra Cuello/Mother 13539 Georgia Ave.Apt.2 Silver Spring,Md 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Remoyal from State 6/08/05 Gate of Heaven Silver Spring, Md 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 5 PHILIP ACTOR TO ALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician O, neurob! Year S resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Examine signed by the attending physician and the detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Cther: 4 Nursing Home Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No al or Attend s after death il Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mayland D0055748 30. Name and dress of pason who completed cause of death (Item 23a) (Type, Print) Ligar Are

State

1 0 2005 Registrar

31. Date filed (Month, Day, Year)

Perez-Hlbueine 39. Registrar's Signature

		1	= For AMEND#20bperFH6/14/ = RegistraMEND#1per MD6/10	State of Marylar	nd / Depa <i>Cei</i>	artment of Heal	th and Menta ath	ıl Hygien Reg. N	e •.2005	2101.0
			Decedent's Name (First, Middle, Last)	ANIVEL	N	ONTEAGUDO	2. Dat	e or Deguii		3. Time of Death
	Physicia		MONTEAGED	n AM	VEL	/	June	4, 20	ay Year 05	9:45 p M
	/Medic		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or Loca	tion of Death	4	c. County of Death	
	Examine	er i	Springbrook Terrace		nter	Silver Spri	ng	M	ontgomer	у
	Funeral Director	Ċ	5. Social Security Number 6. Sex	7. Age (In yrs. 73	. last birthday) Yrs.	If Under 1 Year If U	ador 24 Hrs. a Day	te of Birth onth, Day, Yea 2 9,193	g. Birth Cou 1 Cuba	place (State or Foreign intry)
			Usual Residence of Decedent							10.4 114- 01-11-11-
	yland	- 1	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1X Yes 2 ☐ No
	Mar-f et	ğ	Maryland Montgomery	Si	lver Sp	oring				
	death with the Maryland ms 23a or 28a-f ehow	ā	10e. Street and Number 12325 New Hampshire	Avenue		10f. Zip Code 20904			Citizen of What Cou Lted Stat	
	y within 72 hours after death with the Marylan jiene Than "natural", or Items 23a or 28a-f ehow The Madical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced	. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me 1 X Yes 2 □ No Sp	exican, Fueno nican,	es or No- etc.)	14. Race - Amer Black, White Specify: Bla	e, etc.
215-0036	hour tural		15. Decedent's Educa		16a. Dece	dent's Usual Occupation		16b.	Kind of Business/l	ndustry
င်	in 72	Set	(Specify only highest grade of	completed)	(Give	kind of work done during DO NOT use retired)	most of working	F		nductry
7	filed within 72 Hygiene. other than "nater", in Madic	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Labor	er		Fur	niture I	naustry
andz	othe	0	17. Father's Name (First, Middle, Last)	Jnknown		18.	Mother's Name (First	, Middle, Maid	en Sumame) Un	known
Maryland	and and ls m	၉	19a. Informant's Name/Relationship (<i>Type</i> Ms. Darlene Monteagu			ing Address (Street and N	Jumber or Rural Rout Blvd. Bal	timore,	y or Town, State, Z , MD 2121	ip Code) 8
	1 and Health em 27 ither to	ľ	20a. Method of Disposition		Place of Disp	osition (Name of	6-12-20		Location - City or	
وّ	Pages nent of int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	noval from State	cemetery, cre	matory or other place) coln Cremato	0-12-20	005 005 - Bre	entwood.	MD
altimore,	trant		*4 □ Donation *5 □ Other (Specify) 21. Signature of Furreral Service Licenset		1	O Name and Address of	Facility Cimpla	Tribut	to Funera	1 and
Ba	Deparement of the property of		21. Signature of Full Hall Selvice Icenses	Market	C	remation Cer	nter 1040	Rockvi	lle Pike,	Rockville,
	20394		23a. Part1. Enter the disease, or complication	ations that caused the de	ath Do not ed	b, 20852	ch as cardiac or resp	iratory arrest.		
П			shock, or heart failure. List only one	cause on each line.	O. IL AAZ	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	2000			Interval Between Onset and Death
	Physician	8 1	Immediate Cause (Final disease or condition resulting in death)	CHEDIO	runin	DITHER IT	1631		-	
	/Medical Examiner		resulting in dealth)	Due to (or as a conse	equence of):	NA				
	LAGITITIO	u	Sequentially list conditions, b.	Due to (or as a cons	equance of):	uirj.				
	pe iis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C NOSI	AGG	REPLAL	DISCA	SE		
	ate be executed hysicien and he burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a cons						
8760,	oe ex cien ourial	E		DIABE	TES	MELLITUS				
87	icate be executed physicien and s the burial-transit	dical	d.	01.100						
Box 6	ath certifi ttending or use as	Physician/Med	in the past 12 months?	ic. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	☐Ectopic pregnancy			23d. Date of del Month	ivery Day Year
o.	he de	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
σ	res that the de signed by the a I be detached t	by	Part II. Other significant conditions cont	ributing to death but not r	resulting in the	underlying cause given in	Part I. 2	23e. Did tobacc		the cause of death?
Records	law requires as been sign 2 should be	Completed						24a. Was an	24h Were at	utopsy findings available
ec	e law has b	nple						autopsy performed	prior to death?	completion of cause of
=	That are page	S					1	☐ Yes 2 🖼	No 1 ☐ Yes	2 2 No
Vital	ysicien: Th is certificate director, paç	Be	25. Was case referred to medical examiner?	a anitali		Others	Place of Death Che			
of/	Q	P	1 Yes 2 PNO		ER/Outpati	ent 3LIDUA	4 ☑Nursing Home		e 6 ∐Other (Spe injury occurred	icity)
n c	ding Phi h. After thi funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time Injury	Work?	2 🗆 No	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	at at	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, s	street, factory, office	28f. L	ocation (Stree City or Town, S		ural Route Number,
۵	To the Hospital or Atterwithin 24 hours after de vithin 24 hours after de To the Funeral Directo completely filled in by the	Medical Cer	(Check only 2 Medical Examin	ician: To the best of my liter: On the basis of exam	knowledge, de ination and/or	ath occurred at the time, investigation, in my opinion	date and place, and don, death occurred at	lue to the caus the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	the H hin 24 the F nplete	led	one)	and manner stated.		29c License nu	mber	29d.	Date signed (Mon	th, Day, Year)
	or Too	2	29b. Signature and title of certifier	Mo		NAGE	79	Ti	INFLO	006
•			Allats	' '		0462	4			
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Typ 名ンてA	e, Print) HANOVC	PARKUS	AY Cole	College	MARY LAM
	St	ate	31. Date filed (Month, Day, Year)	32/Registrar's Si	ignature	ands!		., 9,70		

State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#7,8perFH6/13/05,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .2005 **Physician** Year Estelle 6, Elizabeth Mills June 8:52p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Spring Silver Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 927 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 1 1 F 046-20-0350 Yrs. Director Feb. 20 1928 Connecticut Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show injury or other traumatic event, the Medical Examinet must be notified at CT. New Haven Hamden Director ty Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ŏ 25 Chauncey Road 06514 USA or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done di life. DO NOT use retired) during most of working College (1-4or 5+) Elementary/Secondary (0-12) School Crossing Guard Hamden Police Dept 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Khikowski Elizabeth Plovak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Writer/Daughter 623 Edmonston Drive Rockville, Md 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Himportant: If ite any injury or of once. 1 XBurial 2 Cremation 3 Removal from State Beaverdale Mem.Pk6/10/05 * 4 ☐ Donation 5 ☐ Other (Specify, New Haven, CT. 21. Signature of Funeral Service Ucensee PHTLIP D'RINALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) <u>days</u> /Medical Due to (or as a consequence of). Examiner Urinary track infection days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai as the use IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I the 9☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tyes 2 No 3 Probably 4X Unknown cirrhosis of liver Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Ascetes 24a. Was an autopsy performed? certificate Division of Vital 2**X** No Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: P 1 ☐ Yes 2 🔀 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 5 D32332 June 7,2005 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.K.Gupta MD 9801 Georgia Ave. #220 Silver Spring, Md 20902 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar 1. Decedent's Name (First, Middle		Cei	rtificate of			g. No. 200	2 Trush of Bolin 1
/	ıysicia Medic	al	Martha B. McRey	nolds				May 30,	2005	3. Time of Death 5:20 am M
E	kamin	er	4a. Facility Name (If not institution, Manor Care Poto	-	•	Potoma	r Location of Death		4c. County of Dea	
	neral ector		5. Social Security Number 557-14-4347 Usual Residence of Decedent	6. Sex 7. Ag 1 M 2 XF	ge (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/09/19	Year) 9. Bii 09 New	thplace (State or Foreign ountry) York
Maryland	The dat	ctor	Usual Hesidence of Decedent 10a. State 10b. County MD Montgo	omery	10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2X No
ath with the	usi be no	Funeral Director	10e. Street and Number 10714 Potomac Te	ennis Lane		10f. Zip Code 20854		10	g. Citizen of What C	ountry?
BAITIMORE, IMARYIANG Z1Z13-UU35 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Hygiene Important: or items 23a or 28a-f show	Examinarin	þ	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' ed 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	? No	Was Decedent of Hif Yes, specify Cub	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
Baltimore, Maryland 21213-UU35 Dermit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. moorlent: if item 27 is marked other than "natural" or	ie Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		(Give		pation during most of work d)	ring	6b. Kind of Business Hospital	/Industry
//and //	tic event.	To Be Co	17. Father's Name (First, Middle, I John Brasfield					e (First, Middle, M	laiden Sumame)	
, Mary and 2 short salth and N	er treuma		19a. Informant's Name/Relationsh Robert M. McRey			•			City or Town, State, , Maryland	
Imore Pages 1 ment of He	iny are		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 1 □ Donation 5 □ Other (Sp	pecify)	_1	natory or other pla coln Cren	atory 9/1	.0/2005 B	rentwood,	Town, State MD
Dermit.	any In		21. Signature of Fundral Service I	Strock-Show	10	40 Rockv		, Rockvi	lle, Mary	land 20852
rnysi /Med	dical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. <u>Consest</u>	ine. ive Heart I s a consequence of):	Failure			st,	Approximate Interval Between Onset and Death
Exam		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	c Obstructi sa consequence of):	ive Pulmo	nary Dise	ase		
trificate be executed	as the burial-transit	Medical Exar	that initiated events resulting in death) Last	c. Gastr Due to (or as d. Pneu T	s a consequence of):					
ath ce	detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
ecords, F.C. law requires that the	db	by	Part II. Other significant conditio	ons contributing to death l	but not resulting in the u	nderlying cause gn	ven in Part I.			o the cause of death? robably 4 X Unknown
The The	page 2	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of s 2 \(\square\) No
Phy of	funeral dir	tlon; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pendin. 2 ☐ Accident investig	28a. Date of Inj (Month, Da	ient 2 ER/Outpatier ury 28b. Time o lnjury	f 28c. Inju Wo	ner: 4X Nursing Ho	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spe	ecify)
5 2 5	ed in by th	Certification;	3 Suicide 6 Could r 4 Homicide determi	ined 286. Place of in	ijury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
To the Hospitel or within 24 hours el	completely filled in by the	edical	one)	g Physicien: To the best Examiner: On the basis of and manner s	of examination and/or in	vestigation, in my	ppinion, death occur	red at the time, da	te and place, and du	e to the cause(s)
Twitten To	con	2	29b. Signature and title of certifier	LiVoh	amp		0274		ine 8, 200	
			30. Name and address of person Kirti Vohra, MD	, 1299 Lambe	erton Drive		Spring, N	Maryland	20902	
R	Sta egistr		31. Date filed (Month, Day, Year) JUN 10	2005 Regist	trar's Signature	wer				

Mode Day Teach Day			For State Registrar	State of Maryland	-	rtment of F tificate of			giene Reg. No.	200	- 0 1 0 1
JOHN R. MOLTCER 10.09 20.5 4:10 P 10.00 20.5 4:10			1. Decedent's Name (First, Middle, Last)							- UU.	3. Time of Death
4. Facility Attent (for or sentiminary give attent and controlled) 4. Facility Attent (for or sentiminary give attent and controlled) 4. Facility Attent (for or sentiminary give attent and controlled) 4. Facility Attent (for or sentiminary give attent and controlled) 5. Social Security Human (for or sentiminary give attention) 5. Social Security Human (for or sentiminary give attention) 5. Social Security Human (for or sentiminary give attention) 5. Social Security Human (for or sentiminary give attention) 5. Social Security Human (for or sentiminary give attention) 6. Social Security Human (for or sentiminary give attention) 6. Social Security Human (for or sentiminary give attention) 6. Social Security Human (for or sentiminary give attention) 6. Social Security Human (for or sentiminary give attention) 7. Social Security Human (for or sentiminary give attention) 6. Social Security Human (for or sentiminary give attention) 6. Social Security Human (for or sentiminary give attention) 7. Social Security (for or sentiminary give attention) 6. Social Security Human (for or sentiminary give attention) 6. Social Security Human (for or sentiminary give attention) 7. Social Security (for or sentiminary give attention) 8. Social Security (for or sentiminary give attention) 8. Social Security (for or sentiminary give attention) 8. Social Security (for or sentiminary give attention) 9. Social Security (for or sentiminary give attention) 10.			JOHN H.	MOELTER							5 4:10 P
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\$ 5.000 Security Numbers 2.50 per company 2.50			Manor Care Potomac			Potomac			М	ontgome	erv
The State The Country Th	Funeral		5. Social Security Number 6. Sex			If Under 1 Year		8. Date of Birt	h		
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Maryland Montgomery Nontgomery Village 109 Citizen of What Courty?	2										
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Margaret Lewis / Niece 18821 S. Meadow Fence Rd., Montgromery Cipillare, Md 20b. Place of Desposon (Name of Desposon) (Page of	E E E	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin					Town, State,	Zip Code) noo 6
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Due to (or as a consequence of): Due to (or as a consequence of):	sician:	2 T		Pneumonia							
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FFEMALE: 23b Was alsoedent pregnant in the past 12 months? 1	an an		resulting in death) Last	Due to (or as a consequer	ice of):						
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25. Was case referred to medical axaminer? 1	d for	cia	in the past 12 months?				<u>′</u>			Month	Day Year
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25. Was case referred to medical axaminer? 1	sign d be	d b	Renion Prostate Hy	nertrophy				1 🗆 Y	es 2[No 3∏P	robably 4 Unknov
25. Was case referred to medical saminer? 1	peed	ete				-		04-146-		045 144	
25. Was case referred to medical axaminer? 1	has 10 2	ם	Atrial Fibrillation	n				autop	sy	prior to	completion of cause of
27. Manner of Death 1 Manual 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route Number, City or Town, State) 28c. Injury at Work? 1 Yes 2 No 2	cate.	ပိ				<u>-</u>		1 Tes	200 No	1 ☐ Ye	s 2 No
27. Manner of Death 1 Manual 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation one) 29b. Signature and title of certifier 29b. Signature and daress of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, MD 11125 Rockville Pike, #208, Rockville, Md. 20852	ector	Be	examiner?	oenital:		0					
27. Martine to Death 1 Matural 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29m. Certifier Check only one) 29m. Certifier 29m. Certifier 29m. Signature and title of certifier 29m. Signature and title of certifier 29m. Signature and difference of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, MD 11125 Rockville Pike, #208, Rockville, Md. 20852	this (1 165 2 10	1 □ Inpatient 2 □ EH		1 3 DOA	4 Et Nursing Ho				ecify)
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29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, MD 11125 Rockville Pike, #208, Rockville, Md. 20852	death. ctor: A y the fu	cat	E				res 2∐No				
29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, MD 11125 Rockville Pike, #208, Rockville, Md. 20852	within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ħ	dataminad	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office				Number or R	ural Houte Number,
D0053615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, MD 11125 Rockville Pike, #208, Rockville, Md. 20852	rs a.		1								
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, MD 11125 Rockville Pike, #208, Rockville, Md. 20852	To	Σ				29c. Licens	e number	:	29d. Date	signed (Mon	th, Day, Year)
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			30. Name and address of person who co	mpleted cause of death (Item 23	За) (Туре,	Print)					
			Aruna S. Nathan.	MD 1	1125	Rockvilla	Pike #	208. Roy	kvi	11e. MA	20852
	Sta	ite							<u>v</u>	-1-0 110	

■ Baltimore, Maryland 21215-0036 McDonald, Gertucie 6/8/05_ 17:40

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		for State		State of Ma	arylan					Mental H	ygien	е		
		Registrar	- (Final Atlanta La	-41		Ce	ertifica	te of	Death	100.00	Reg. N	0200	01	-
Physici	an		e <i>(First, Middl</i> e, La TRUDE: N	st) /IRGINIA	McI	OONAI	.D			2. Date of D Month JUNE		2005 Yea	r	me of Death
/Medic Examin				e street and number)				/. Town. o	r Location of Deat			c. County of De		40 M
LAdillii			ban Hos						hesda			MONTO		Y
Funeral		5. Social Security N		Sex 7. Ag		ast birthday	/) If Und	er 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of B	Birth Day, Year	9. E	irthplace (S	state or Foreign
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/land		10a. State	10b. County		10c. City	, Town or L	ocation						10d. Ins	ide City Limits
the Mar. 28a-fst	ctor	MD	Monte	gomery	1		Ker	nsin	gton				11/2	Yes 2□No
be filed within 72 hours after death with the Maryland tal Hygiene. It has Hygiene. I other than "natural", or items 23a or 28a-f show avent, the Medical Evanimer must be inclined at	Funeral Director	10e. Street and Nu		1/11 De-A			10f. Z	ip Code	2000		10g. C	itizen of What	-	
s 23a	rai		Piyers I	Mill Road		2 142			20895			U.S.Z	-	
tter de	Fune	11. Marital Status 1 □ Never Mari	ied 2XMarried	12. Was Decedent Armed Forces? 1 ☐ Yes 2 €		5. 13.	If Yes, sp	edent of H ecify Cuba	lispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	10-	14. Race · Ar Black, Wi		an,
al', or	by	3 Widowed		If Yes, Give Year or Dates:			1 🗌 Yes	2 X No	Specify:			Specify:	Black	
72 hc natur	Completed	(Spec	15. Decedent's E	ducation ade completed)		16a. Dec	edent's Us	ual Occup	ation during most of wo	rkina		Kind of Busines		
within ane. than	ldm	Elementary/Seco		College (1-4or 5	5+)				s Aide			ontg.		
filed v Hygie sthar ant, t		9th 17. Father's Name	(First, Middle, Last)			.eacı	тет	18. Mother's Na	me (First, Midd		chools		
id be lental kad c	To Be	Wa	lter W.	Johnson	. sr					Mae F				
2 should and Men Is marka raumatic	-	19a. Informant's N	ame/Relationship (Type, Print) (Hus	band	1)9b. Mai	ling Addre	ss (Street	and Number or R	ural Route Num	ber, City	or Town, State	, Zip Code)	
and 2 ealth m 27 I				onald, Sr					rs Mill					
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury groups reaumatic avant, the Medical once.		20a. Method of Dis 1 Surial 2	•	Removal from State	20b. Pl	ace of Disp empters, cre	oosition (Na ematory or	ame of other plac		Date		_ocation - City		ite
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permit. Departn Importa any inju		21. Signatureoi Fi	DA 1 0 2	There	لررمه		/		ss of Facility S ash. St					•
		23a. Part1. Enter	the disease, or com	plications that caused	the death		1			-			Appro	ximate
Physician		shock, or hea Immediate Cause disease or condition	(Final	one cause on each li	DED 1	run	uns	17	MARIE				Onset	al Between and Death
/Medical		resulting in death)		Due to (or as	a consequ		1,07		7//0/1	, ,				
Examiner		Sequentially list co	onditions,	b. Pui		VM.	9	em!	30145					
ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or	nmediate erlying	Due to (or as	a consequ	ience of):								
be executed sician and burial-transit	xan	that initiated event resulting in death)	S	c Due to (or as	a consequ	ience of):								
e be e			·	d										
The law requires that the death certificate the law requires that the death certificate the has been signed by the attending physic page 2 should be detached for use as the bare.	Physician/Medical	IE EEN AN E												
ath cei ttendir	an/h	IF FEMALE: 23b. Was deceder in the past 12		23c. If yes, outcome			□Ectopic	pregnancy	,			23d. Date of d	,	
the at	/sici	1 Yes 2	NAO	4□Pregnant at 9□ Unknown	time of de	ath 5	Other (specify)				Month	Day	Year
that the de				contributing to death b	ut not resu	Iting in the	underlying	cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the caus	e of death?
uires uires raign ld be	d by	/ .	withour	4			, ,	3		1 🗆	Yes 2	2□No 3□	Probably	4 DUNKNOWN
w requ	Completed		_							24a. Wa	ıs an	24b. Were	autopsy find	lings available
The lav	omp									aut per 1 ☐ Yes	opsy formed? 2 349	prior to death	o completion	n of cause of
sician: The certificate hir	BeC	25. Was case reference	rred to medical						26. Place of De			0 1010	20140	
Physic this ce	To	1 ☐ Yes 2 ☑		Hospital: 1 Inpatie		ER/Outpatie	ent 3 🗆 🗆		4 🗀 INUISING F	Home 5 Re	sidence	6 □Other (Sp	ecify)	
ding P	lon	27. Manner of Dea 1 CHatural	5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time Injury		28c. Injur Wor		28d. Describe	how inju	ury occurred		
death ctor: y the	Certification:	2 Accident 3 Suicide	investigatio	On Disco of Inc	urv - At ho	me farm s	M treet facto		Yes 2 □No	28f Location	(Street a	and Number or	Qural Route	Number
after after Dira	ertii	4 🗌 Homicide	determined	building, et	c. (Specify)	ireot, izoto	ry, omco			own, Stat		iurar ricute	ramber,
ospita hours unaral y fille		29a. Certifier (Check only	Certifying Pl	nysician: To the best	of my know	wledge, dea	ath occurre	d at the tin	ne, date and place	e, and due to the	e cause(s	s) and manner	as stated.	
To the Hospital or Attending Physician: within 24 hours alter death within 24 hours alter death or to the Funaral Director. After this certifical completely filled in by the funeral director,	Medical	one)		miner: On the basis o and manner sta	t examinat	ion and/or i	nvestigatio	n, in my o	pinion, death occi	urred at the time	e, date ar	nd place, and di	Je to the ca	JSB(S)
To To T	Σ	29b. Signature and	tritle of certifier	1010			25	9c. Licens	e number			ate signed (Mo.		ŕ
<		1/1	100	0 000				W	2 S_o	4774	N	NV 9	20	25
1		30. Name and add	ress of person who	completed cause of o	leath (Item	23a) (Type	e, Print)	M-T	and in	200 25	77450	NV 9	200	564
Sta	ite	31. Date filed (Mor	nth, Day, Year)	3 Registr	ar's Signat	ure	000	70 /6	1/20	TAN O	,, ,,			
Registi		J	JN 15 20	105 Keene	, St.	AND	THE REAL PROPERTY.							

	1 - For State Registrar	State of Maryla		ertificate of			2000	2101
	Hegistrar Decedent's Name (First, Middle, La.	st)		sitincate of		Reg 2. Date of Death	g. No U []	3. Time of Deat
n	Eleanor	Blanche	N	1cQuaid		Month	Day Year	2
1	4a. Fecility Name (If not institution, giv		1.		r Location of Death	June	10, 2005 4c. County of Dea	3:45
r	Fairland Advent		Rehab.		ver Spring		Montgom	
	Social Security Number 6. S				If Under 24 Hrs.	B Date of Birth	9 8	rthplace (State or Fore
		1□M 2 K F 8	,	Months Days	Hours Min.	(Month, Day, sarch 9,	1923 We	st Virgini
	10a. State 10b. County	10c. C	ity, Town or I	Location				10d. Inside City Lin
0	Maryland Mon	tgomery	Silve	r Spring				1 ☐ Yes 2 ₹☐
Director	10e. Street and Number	3-1-1		10f. Zip Code		10	g. Citizen of What C	Country?
	9636 Cottrell	Terrace		20903			USA	
Funeral	11, Marital Status	12. Was Decedent Ever in U	J.S. 13	. Was Decedent of H	lispanic Origin? (Spec	ify Yes or No-	14. Race - Am	erican Indian,
5	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No			an, Mexican, Puerto R	ican, etc.)	Black, Wh	
2	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: Wh	ite
	15. Decedent's Ed		16a. Dec	edent's Usual Occup	pation	10	6b. Kind of Business	s/Industry
5	(Specify only highest gra	ade completed) College (1-4or 5+)	(Giv life.	re kind of work done . DO NOT use retire	during most of working d)	7		-
Completed	6	CO1098 (1-401 34)	Но	memaker			Own Hom	е
υ	17. Father's Name (First, Middle, Last,)			18. Mother's Name (First, Middle, Ma	aiden Sumame)	
2	Dominic Greco				Nicolina	Michie	nzi	
	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	iling Address (Street	and Number or Rural	Route Number,	City or Town, State.	Zip Code)
	Patricia Guynn/	Daughton			oad, Adelp			
	20a. Method of Disposition	20b.	Place of Disp	position (Name of	Da	te 20	oc. Location - City o	
	1 Burial 2 Cremation 3	THemoval from State		ematory or other place. In Cemetery	^{ca)} June 20	05 ¹⁴ , B	rentwood,	Mary I and
	* 4 □ Donation 5 □ Other (Specification 21. Signature of Fineral Service Lices	97		-	sscofiquins F			Maryrand
Examiner	resulting in death) Sequentially list conditions, if any, leading to miniodate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	÷	5 Years				
	resulting in death) Last	Due to (or as a conse	quence of);					
edi								
an/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of de Month	elive ry Day Year
VSIC							con use contribute t	
	Part II. Other significant conditions of	contributing to death but not re	sulting in the	underlying cause an	en in Part I	23e Did toha		o the cause of death
ò	Part II. Other significant conditions of Breast Cancer. Dr							
ò	Part II. Other significant conditions of Breast Cancer, D.							
ò						1 Tyes 24a. Was an autopsy performe	2 No 3 P	robably 4 🗷 Unknutopsy findings avail completion of cause
e completed by	Breast Cancer, D					1 Yes 24a. Was an autopsy performe 1 Yes 25	2 No 3 P 24b. Were a prior to death? ☑ No 1 □ Ye.	o the cause of death robably 4 XJUnkn utopsy findings avail completion of cause s 2 \(\square\$ No
o pe completed by	Breast Cancer, D	iabetes Mellit	us Ty	pe II, Hyr	Dertension 26. Place of Death (1 Yes 24a. Was an autopsy performe 1 Yes 25 Check only one	2 No 3 P 24b. Were a prior to death? No 1 Yes	robably 4 🖄 Unknutopsy findings avail completion of causes s 2 🗆 No
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ertification: To Be Completed by Physician/Medical	Breast Cancer, D. 25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death	Hospital: 1 Inpatient 2 Inpati	ER/Outpatic 28b. Time Injury	ent 3 DOA Oth of 28c Injur Mo	26. Place of Death (er: 4 X Nursing Homey at K? Yes 2 \(\text{No.} \) No	1 Tyes 24a. Was an autopsy perform 1 Yes 25 Check only one, 9 5 Resident d. Describe how	2 No 3 P 24b. Were a prior to death? No 1 Ye. ce 6 Other (Sperinjury occurred	robably 4 ⊠Unkn utopsy findings avail completion of cause s 2 □ No
edical Certification: To Be Completed by	Breast Cancer, D. 25. Was case referred to medical examiner? 1	Hospital: Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h	ER/Outpatic 28b. Time Injury nome, farm, s	ent 3 DOA Other of 28c Injury Wor M 1 street, factory, office	26. Place of Death (er: 4 X Nursing Home y at k? Yes 2 \(\text{No} \) 28 me, date and place, an	24a. Was an autopsy perform 1 Yes 25 Check only one; 9 5 Resident d. Describe how of Location (Stree City or Town,	2 No 3 P 24b. Were a prior to death? I No 1 Ye. Ce 6 Other (Sperinjury occurred Det and Number or F State)	utopsy findings avail completion of causes 2 No scrify)
o Be Completed by	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b determined 29a. Certifier 1 Creck golf 2 Medicel Exer	Hospital: 1 Inpatient 20 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - Ath building, etc. (Specing Sicient): To the best of my kminer: On the basis of examin	ER/Outpatic 28b. Time Injury nome, farm, s	ent 3 DOA Other of 28c Injury Wor M 1 street, factory, office	26. Place of Death (er: 4 X Nursing Homey at K? Yes 2 \(\text{No} \) The date and place, an pinion, death occurred.	24a. Was an autopsy perform 1 Yes 25. Check only one, a 5 Resident d. Describe how of Location (Stree City or Town, and due to the caulant the time, dat	2 No 3 P 24b. Were a prior to death? I No 1 Ye. Ce 6 Other (Sperinjury occurred Det and Number or F State)	robably 4 ⊠Unkn utopsy findings avail completion of cause s 2 □ No ecify) ural Route Number, s stated, e to the cause(s)
edical Certification: To Be Completed by	Breast Cancer, D. 25. Was case referred to medical examiner? 1 Yes 2½ No 27. Manner of Death 1 ½ Natural 5 Pending investigation 3 Suicide 6 Could not b determined 29a. Certifler (Check only one) Check only one)	Hospital: 1 Inpatient 20 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - Ath building, etc. (Specing Sicient): To the best of my kminer: On the basis of examin	ER/Outpatic 28b. Time Injury nome, farm, s	ent 3 DOA Other of 28c. Injury Mor 1 street, factory, office ath occurred at the tirinvestigation, in my control 29c. Licens	26. Place of Death (er: 4 X Nursing Homey at K? Yes 2 \(\text{No} \) The date and place, an pinion, death occurred.	24a. Was an autopsy perform 1 Yes 25. Check only one, a 5 Resident d. Describe how of Location (Stree City or Town, and due to the caulant the time, dat	2 No 3 P 24b. Were a prior to death? I No 1 Ye. Cee 6 Other (Speriment of State) State) See(s) and manner a e and place, and du	utopsy findings ava completion of caus s 2 \(\text{No} \) No actify) aural Route Number s stated. e to the cause(s) th, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

22. Registrar's Signature

Ravi Passi, M.D.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar		ryland / Dep	artment of Herrificate of D	ealth and M	lental Hygi	ene g. No,2 () ()		210	1.8
Physici /Medic		Doris Mary Moyni					2. Date of Death Month June	7 20	o5	3. Time of 0	P M
Examin	er	4a. Facility Name (If not institution, give s Anne Arundel Medi 5. Social Security Number 6. Sex	cal Cente	(In yrs. last birthday)		inapolis If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 14		e Aru	e (State or	r Foreign
Director		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Li			June 14	1921		Inside City	y Limits
vith the Ma r or 28a-f	Directo	Maryland Anna Anna Anna P.O. Box 236	runae1		Crownsvi	032	10	Og. Citizen of Wh		1 🗆 Yes	*****
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examination willied at ODGE.	Funeral Director		12. Was Decedent Ended Forces? 1 Yes 2/2000	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spi , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	.S.A. American White, etc		
n 72 hours a "netural", c	Completed by	3∕CX/Vidowed 4 □ Divorced 15. Decedent's Eduction (Specify only highest grade)	Year or Dates: cation completed)	(Give	dent's Usual Occupate kind of work done du DO NOT use retired)	Specify: tion uring most of work	ing	Specify:			
filed withi Hygiene. other than	Be Comp	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Salesper		e (First, Middle, N	faiden Surname)	etail		
should be and Menta s marked	ToB	unknown 19a. Informant's Name/Relationship (Type			ing Address (Street as			City or Town, St			
of Health of Health of Item 27 i		John T. Moynihan, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R			O. Box 236 osition (Name of matory or other place			laryland 20c. Location - C			
permit. Page Department (Important: II any injury or		*4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service License	1	Maryland	Vets. Cen 2. Name and Address	ı. 6/1	3/2005 hn M. Ta				
Physician /Medical Examiner	her	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a	he death. Do not en CICULATION consequence of):	- FIBRILI	such as cardiac of	or respiratory arre	st,	Ar In Oi	PD 21 oproximate terval Betweenset and Di	veen
ires that the death certificate be executed signed by the attending physician and be detached for use as the buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a	CONSEQUENCE OF):	NDUNT	DIAMET	es ma	كالمالد			
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	-		23d. Date Month		y Yo	ear
w requires that been signed I should be det	by	Part II. Other significant conditions con	, 6steopo	cosis, i	mixed co	nnective		acco use contrib	ute to the d		
ician: The law r certificate has be rector, page 2 sh	Completed	tissue disease			nt conce	4	24a. Was ar autopsy perform 1 \(\text{Yes} \)	y prid ned2 dea	ere autopsy or to compl ath? Yes 2	findings a letion of ca	vailable use of
ing Phys After this uneral dii	Certification: To Be	25. Was case referred to medical examinar? 1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	Year) 28b. Time of Injury	of 28c. Injury Work	es 2 No		nce 6 Other w injury occurred		oute Numb	De <i>r</i> ,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	dicai Cert	29a. Certifier Check only 2 Medicel Exemi	sician: To the best of	my knowledge, dea	th occurred at the time	a, date and place,			ner as state	d. e cause(s)	
To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stat	ed.	29c. License	number 1997	29	ed. Date signed (Month, Day	y, Year)	
		30. Name and address of person who con ANDREW GORDON	mpleted cause of de	ath (Item 23a) (Type	1 PKwzy	St 100 1	ANNAPO	LK, M	<u>n</u>	.140	7/
Sta Regist	ate	31. Date filed (Month, Day, Year)	3 PHBGISTIZA	r's Signature	and a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#20b-c.perFH_G845.7/20/05 TT

Ame ner	no #1.P	20	Tysfor PCC 6 State C Pe Registrar Pc		,gc,	6/10/	05	nd'/ Depa <i>Ce</i>	rtificate				2. Date o	Rec	g. NQ ()	05.	21010
	Physici /Medi	cal		<u>Maybel</u>	1e	Mich		AYBELL			1		Month June			2005	3. Time of Death 12:50 p
	Examir	ner	4a. Facility Name (46. City, 1		Location of	Death				y of Death	y Co.
	Funeral Director		5. Sociat Security N 251-14-0	lumber	6. Sex		7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date o (Month	f Birth , Day, 1	(ear) 1919	9. Birthp Cour Sout	place (State or Foreign htry) h Carolina
	and w		Usual Residence o	f Decedent 10b. Count	у			ty, Town or Lo	ocation								0d. tnside City Limits
	Mary 9-1 ehc	tor	MD	Mont	gomer	y Co.	Si	lver S	pring								1 ZXYes 2 ☐ No
	or 280	Director	10e. Street and Nu	mber					10f. Zip (Code				109	g. Citizen of	What Cour	ntry?
	e 23a	rai	2601 Bel	L Pre I		144		10 10	209			. 0 (0			USA		7 17 -
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Heatth and Mental Hygiene. I then 27 is marked other then "natural; or item 27 is marked other then "natural; or items 23a or 28e-1 ehow other treumatic event, if a Medical Even it arrivant to incillise at	by Funeral	 Marital Status Never Marr Widowed 		rried	Amed For 1 Yes 1 t Yes, Give Year or Da	2 y € No	1	Was Decede It Yes, speci 1 Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto	ecity Yes o Rican, etc	r No- .)	Bla	ice - Americ ack, White, ify: Blac	etc.
5-0036	72 ho	eted	(Spec	15. Decede				16a. Dece	dent's Usual kind of work DO NOT use	Occupa done d	tion uring most	of worki	na	10	6b. Kind of E		
121	within lene. then "	Completed	Etementary/Seco 7th			College (1-	4or 5+)		DO NOT use undre s						Priv	ate	
	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, If a Ma	Be C	17. Father's Name	(First, Middle	, Last)			1.					(First, Mi	ddle, Ma	aiden Suma	me)	
Maryland	should be I nd Mental I rmarked o umatic eve	To	unknown	le e d'Delevie	able (Ton	Deleat		405 14-20			unkno		10-11		O' T	Q:	
N N	and 2 sh ealth and n 27 is n iar treun		England			•			ng Address (Palme 1						-		,
Baltimore,	Pages 1 and 2 nent of Health int: if item 27 I		20a. Method of Dis 1 XBurial 2 4 Donation	position Cremation	3 □Rer			Place of Dispo cemetery, creating	sition (Name	of er place	9)	C	Date 14/0!	S S	oc. Location	- City or To	
Baltii	permit. Pages Department of Importent: if i any injury or gnes		21. Signature of F			Lo	n X	2:		Addres	s of Facility	John		and	Jenki	ns Fu	neral Homo
	Pnysician /Medical Examiner		23a. Part1. Enter shock, or hea tmmediate Cause disease or condition resulting in death)	(Finat	or complicationly one	R	used the dea ich line.	tony	Faile				or respirato	ory arres	st,		Approximate Interval Between Onset and Death
,0°		edicai Examiner	Sequentially list of any leading of it cause. Enter Und Cause (Disease of that initiated event resulting in death)	nmediala erlying r injury s	b. c.	Due to (d	or as a conse	V.55	eact i	Fai	lure						years
68760,	cate b physic the bi	dica		.*	d.												
O. Box 6	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transl	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2, 9 Unknown	months?	230	1 🗆 Live bi	come of pregn rth 2 Fet ant at time of wn	al death 3[□Ectopic pre					_	1	ate ot delive	ery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other signi						inderlying ca	use give	n in Part I.				icco use cor 2 □ No	ntribute to tl	ne cause of death?
l Records,	ician: The law requi certificate has been rector, page 2 shoulk	Completed	_ Car	diam	Yapa	Phy	ronay							Was an autopsy performed 2 (ed?	. Were auto prior to co death?	psy findings available mpletion of cause of
of Vital	Phyeician: r this certific ral director,	Be	25. Was case refe examiner?	_		spital:				Othe	26. Place						
on of	hye this al dii	tion: To	1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☐ Naturat 2 ☐ Accident	th 5 Pend		28a. Date of		28b. Time of tnjury		c. Injury Work	at Nur				ce 6 □Ot v injury occu		y)
Division	ei or Attending F s after death. si Director: After ed in by the funer.	edical Certification;	3 Suicide 4 Homicide	6 🗌 Could deter	d not be mined		of Injury - At h	nome, farm, st	reet, tactory,	office			28t. Locati <i>Cit</i> y o	on (Stre r Town,	et and Num State)	ber or Rura	I Route Number,
	e Hospitei 24 hours a e Funerei letely filled	dical (29a. Certifier (Check only one)	1 Certify 2 Medica	ing Physic Il Examine	r: On the ba	isis of examin	owledge, deat ation and/or in	h occurred a vestigation,	t the tim	e, date and inion, deat	d place, h occurr	and due to ed at the t	the cau	use(s) and m se and place	nanner as s , and due to	tated. the cause(s)
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	(3)		30. Name and add	11/	n who com			m 23a) (Type,		e Pi	hdip	D-,	Olas	7		2083	
	St Regist	ate rar	31. Date filed (Mo		r) for	32. Re	egistrar's Sign	ature									

			State of Maryland / Department of Health and M	lental Hygic	ene	
		•	For State Registrar Certificate of Death		NOO A A CON.	21050
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al .	Dorothea Marie Malec 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	June 19	Day Year 2005	0400 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frostburg Village Nursing Home Frostburg		Allegan	3.7
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign
	Director		394-22-0541 10 90 Yrs. 90 Yrs.	April	18,1915I	
	land bw		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location		1	10d. Inside City Limits
	Mary a-f she	tor	Maryland Allegany Frostburg			1 ☐ Yes 2X No
	or 284	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	ntry?
	s 23a	ral	One Kaylor Circle 21532	acifu Vac or No	USA 14. Race - Americ	can Indian
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	Rican, etc.)	Black, White,	etc.
99	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: W	Nhite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Itams 23a or 28a-f show the Modical Exeminat must be mullified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. Do NOT use refired)	ing 16	b. Kind of Business/In	dustry
12	withir iene. than	omp	Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife		Own Hom	ne
	a filed al Hygid other vent,	BeC		e (First, Middle, Ma		
ylaı	should ba nd Mental markad o	Tof	Jeremiah Richards Glenna			
Maryland	d 2 sh th and 7 Is rr treur		19a. Informant's Name/Relationship (Type, Print) Mark Malec-Son 19b. Mailing Address (Street and Number or Run 16700 Harwood Dr.,			
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. item 27 is marked other than "naturel", or Itams 23e or 28e-f show other treumatic event, it. Medical Exerciter must be muilted at		20a Method of Disposition 20b. Place of Disposition (Name of	Date 20	c. Location - City or To	
mo	Page nent o ant: If ury or		1 Burial 2 □ Cremation 3 □ Removal from State A □ Donation 5 □ Other (Specify) Commetery, crematory or other place) Rest Lawn Mem. Gardens	23,2005	LaVale,	MD
Baltimore,	permit. Pages. Department of I Importent: If ite eny injury or of once.		21. St. ature of Funeral Service Licensee 22. Name and Address of Facility	orvice	Dλ	
_	⊄ D ⊆ e ol		23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	wy LaV	ale, MD a	1502 proximate
L	*		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Septice ma		,	Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):		-	o acceps.
P	Examiner		Sequentially list conditions, b.		_	
7	ed isit	niner	Sequentially list conditions, if any, leading to immediate outs. Enter Underlying Cause (Disease or injury)			
*	be executed sician and burial-transit	Examiner	that initiated events c			
8760,	death cartificate be executed e attending physician and nd for usa as the burial-transit	call	d			
9	artifica ling ph a as th	Med	IF FEMALE:			
Вох	leath cartific attending p I for usa as f	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fedal death 3 Ectopic pregnancy 1 Live birth 2 Fedal death 5 Other (specify)		23d. Date of deliv Month	ery Day Year
o.		hysle	1 ☐ Yes 2 MNo 9 ☐ Unknown 9 ☐ Unknown			
s, P	law requires that the as baen signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to t	1
ord	v require		Bilaleval Meumonia	1 L Yes	2 No 3 Prol	
Records,	elawrehas ba	Completed	Severe Parkin Sons Discase	24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Vital F	ician: The l certificate ha rector, page	e Co	Anemia. Addi Son's Di Seone 25. Was case referred to medical 26. Place of Deat	1 ☐ Yes 2 de la (Check only one)	No 1 ☐ Yes	2□ No
	Physician: this certificantal director,	OB	examiner? Hospital: Other		ce 6 Other (Speci	fy)
n of		on: T	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	
Division	Attendii er death. rector: A by the fu	icatl	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	28f Location (Stre	et and Number or Run	al Route Number
Divi	l or Atten after deat Director:	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the cau	se(s) and manner as s	stated.
	the H hin 24 the Fi	Medical	one) and manner stated. 29b. Signature and title of certifler 22c. License number		I. Date signed (Month,	
N	T wit	-	Schamodisis NO D14464		6/21/2	2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-1-11	
	6		DR. SL. SANDHIR 48 TARN TERR FRO.	STBURG	5 MD 2	1532
	Sta Regist	ate rar	31. Date filed (Month, Pan Yex) 4 2005 32. Phistrar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

		•	State of Maryland / Department of Health and Mental Hygiene 1- State State Certificate of Death Reg. No. 2010	ı.
I	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vest	A
	/Medic	al	Edgar Allen McCoy 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	Л
	Examin	er	UNION HOSPITAL ELKTON CECIL.	
	Funeral Director		5. Social Security Number 213-16-9156 6. Sex 7. Age (In yrs. last birthday) 83 Yrs. 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year) March 8, 1922 9. Birthplace (State or Foreign Country) March 8, 1922 9. Birthplace (State or Foreign Country) March 8, 1922	n
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	s
	a-fsh	ctor	Maryland Cecil Elkton 1™Yes 2□N	0
	with th	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	death ms 23	neral	1 Price Drive 21921 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	—
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23a or 28a-f show other traumatic event, Ita McJical Erdring in the ast two multified at	by Fur	Armed Forces? World If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2□ Married 1 ☑ Yes 2 □ No World If Yes, Specify: 3 ☒ Widowed 4 □ Divorced Year or Dates: War II 1 □ Yes 2 ☒ No Specify: White	
21215-0036	72 hou	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business/Industry	
121	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 Warehouse Manager Furniture Retail	
	e filed al Hygid other vent, L	Be Cc	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Maryland	ould be Mental warked o	ToE	Edgar Cummings McCoy Susan Bennett	
Mar	s t and 2 should be Health and Mental tem 27 is marked o other traumatic eve	8 1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar A. McCoy/Self 1 Price Drive, Elkton, Maryland 21921	
ore,	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other once.		20a. Method of Disposition 1 \(\forall \) Burial 2 \(\subseteq \) Cremation 3 \(\subseteq \) Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake City,	
Baltimore,	permit. Pag Department Important: eny injury o	. 4	`4 □Donation 5 □Other (Specify) Bethel Cemetery 2005 Maryland	_
Ba	Depar Impor eny ir	. 4	21. Signature of Funeral Service Licensee Whicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final	
	/Medical		Immediate Cause (Final disease or condition resulting in death) BLADDER CANCER. Due to (or as a consequence of):	-0
	Examiner		Sequentially list conditions. ANEMIA. 124 day	ζ
V	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or Injury) CONCESTIVE HEART FAILURE: 1 4000	-
,	cate be executed physician and the burial-transit	Exal	that initiated events resulting in death) Last Due to (or as a consequence of):	
98760	icate be physicia s the bur	dlcal	d	
Box 6	leath certific attending p	ın/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery	
P.O. B	the the	Physician/M	In the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year Standard	
	res that thighed by be detact	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
Records,	v requir been si should	eted	1 Yes 2 No 3 Probably 4 Winknow	
Rec	0 5 0	Completed	24a. Was an autopsy findings availab prior to completion of cause of death? 1 ✓ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No	8
Vital	Physicien: The this certificate al director, pages	o Be C	25. Was case referred to medical examiner? Hospital: Others	-
of	Phys rthis ral dii	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	-	
ion	Attending Pr r death. ector: After th by the funeral	atlo	2 Accident investigation M 1 Yes 2 No	
Division	i or Att after de Directe	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within ?	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	1		D59398 June 16, 2005	
_	Lex'		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALOK RUSTOGI, MD UNION HOSPITAL, ELKTON, MD.	
	Sta Regista		31. Date filed (Month, Day, Year) JUN 2 4 2005 32. Segistrar's Signature	

MCCOY, EDGAR

			1 _ State	State of Maryla		artment of H			2000	21050
			Registrar 1. Decedent's Name (First, Middle, Last)			tineate of	Dealit	2. Date of Death	g. No.	3. Time of Death
	Physici	an	ALBERTA NEWSOM	Œ				Month	Day Year	
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City. Town. o	r Location of Death	June	06 2005 4c. County of Death	4:05 P ^M
	Exami	eı	Mariner Health of		ino		Spring		Montgome	
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hrs.			nplace (State or Foreign untry)
П	Director		237.20.8152	M 2⊠F 86	Yrs.	Months Days	Hours Min.	April 2	4,1919 Gol	dsboro, NC
	p ,		Usual Residence of Decedent 10a, State 10b, County	100.6	Sib. Taura and					
	shov	_			City, Town or Lo	cation				10d. Inside City Limits 12∑XYes 2 □ No
	M e M	Director	Maryland Prince Geo	orge's H	yattsvi					
	with t	ä	10e. Street and Number			10f. Zip Code	2	10	g. Citizen of What Co	untry?
	be filed within 72 hours after death with the Maryland lal Hygiene. d other than "netural", or items 23a or 28e-f show avent. I'm Medical Eracini at mal be neithed at	Funeral	2517 Avalon Place	2. Was Decedent Ever in	11 6 12 1	2078.		positu Voe er Ne	U.S.A.	ioen Indian
	iter d	Ē	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	Black, White	
920	urs al	β	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: B1	ack
Maryland 21215-0036	2 ho	ted	15. Decedent's Educ	eation		dent's Usual Occup		. 1	6b. Kind of Business/l	ndustry
2	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most of word)	King		
2	filed within 72 Hygiene. other than "nei ant, It.e Medic	Completed		2 Years	I	lomemaker			Domestic	
ם	pe filed tal Hygi d other svent. I	a	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	faiden Surname)	
<u>X</u>	should be fand Mental is marked or umatic ave	ဥ	Arzamous Waters				Lumine	-0-		
a	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any Injury of other traumatic av ang Injury of other traumatic av		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, Z.	ip Code)
e o	l and lealth m 27 her t		Robert R. Newsome		2517	Avalon sition (Name of	Place, Hy	Date 2	e, Marylan	1 20783
0	ges Fort		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	emoval from State	cemetery, crei	natory or other plac	· 1		0c. Location - City or 1	•
Baltimore,	t. Pa		'4 □Donation 5 □ Other (Specify)						Adelphi, Ma	ryland
Ba	Department of the post of the		21. Signature of Funeral Service License	1	H	INES-RINA	LDI FUNE	RAL HOME,	INC.	
			23a. Part1. Enter the asease, or complic	cations that caused the de-						g. MD 20904 Approximate
			shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.		,,,	,	,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Sepsis Due to (or as a conse	navanaa afti					2 Weeks
P	Examiner			Due to (or as a conse	equerice oi).					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):					
	cuted id ansit	Examiner	that initiated events							
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
8760,	cate be executed physician and the burial-transit	dical	d.							
9	e as t	Mec	IF FEMALE:							
Вох	eath certifi attending I for use as	ician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnancy	/		23d. Date of deliver Month	rery Day Year
	at the de by the a tached f	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5L	Other (specify)				
0	The law requires that the death certifit te has been signed by the attending to page 2 should be detached for use as	Physi	Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	nderlving cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	signed I	d by	Urinary Tract_I			, , , ,			s 2⊠No 3∏Pro	
Ö	w require been sign	ete	Dementia, Hyper		h d -			24a. Was an	24h Mara sut	and findings available
Re	The lav	Completed	Dementia, hyper	tension, by	spnagra			autopsy	prior to c	opsy findings available ompletion of cause of
Vital		e C	25. Was case referred to medical				00 Di		X No 1 ☐ Yes	2 No
5	Physician: r this certific ral director,	0 B	examiner?	ospital: 1 Inpatient 2[☐ ER/Outpatier	t 3 DOA Oth	00	th (Check only one	nce 6 □Other (Spec	(6.)
o	g Phy er thi	ı: T	27. Manner of Death	28a. Date of Injury	28b. Time of	The second second		28d. Describe how		197
Division	Attending In death. actor: After by the funer	atio	1 Accident 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □No			
<u> </u>	or Atten after deat Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Rui	al Route Number,
ā	itaio rs aft ral Di	Cer		, , , , , , , , , , , , , , , , , , , ,				J., J. J. J. J. J. J. J. J. J. J. J. J. J.		
	To the Hospital or A within 24 hours after To the Funeral Dira completely filled in by	edicai	(Check only 2 Medical Examin	icien: To the best of my kr er: On the basis of examin	nowledge, death nation and/or in	occurred at the tir	ne, date and place pinion, death occu	, and due to the car	use(s) and manner as : te and place, and due !	stated. to the cause(s)
	the thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			d. Date signed (Month,	
	Z ≥ Z		MILLOA	adhite	lun, M		0576		une 10, 20	
	5		20 Name and address of several	····			, - , - 6	JU 3	- 10, 20	
			30. Name and address of person who cor Aruradah Arun, MD				ite #209	, Silve S	pring, MD	20910
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature				-	
	Registr		JUN 14 200	b Man	M. Do	alle				

			State of Market Registrar	aryland / Depa		of He	ealth a				0.05	21053
	Physici /Medic		Decedent's Name (First, Middle, Last) Lloyd Alan Neese						2. Date of Dear		2005 Year	3. Time of Death 3:49 A. M
	Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospit	al	4b. City, To	ma 1	Park				ounty of Death ontgomer	У
	Funeral Director		5. Social Security Number 466-66-2334 Usual Residence of Decedent 6. Sex 1 ★ M 2 □ F	e (In yrs. last birthday) 60 Yrs.	If Under 1 Months [Year Days	Hours	Min.	8. Date of Birth (Month, Day May 7, 1	^{Year)} 945	Cour	place (State or Foreign ontry) Ginia
	Maryland	tor	10a. State 10b. County Maryland Prince George's	10c. City, Town or Lo							1	10d. Inside City Limits 1 √Yes 2 □ No
	3a or 28a-	i Director	10e. Street and Number 1906 Oliver Street	_	10f. Zip C	ode	207	82	1		en of What Coul	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at anone.	by Funerai	11. Marital Status 12. Was Decedent Armed Forces? 1 Never Married 2 Married 1 Yes 2 1 Yes Give Year or Dates:	No	Was Deceder If Yes, specify		panic Origi , Mexican, Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		4. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036	d within 72 ho giene. Ir then "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or and a completed)	(Give	dent's Usual C kind of work DO NOT use Form M	done du retired)	inng most o	of workir	-		of Business/In	
/land	ould be file Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Donald E. Neese			I	Alva	E.	(First, Middle, I Lawh	orne		
, Mar	and 2 sho ealth and m 27 le m her traum		19a. Informant's Name/Relationship (Type, Print) Alva L. Langworthy -mother	3114	Gracef	ield		, #11	2 Silve	r Sp		ryland20904
Baltimore,	tment of H tant: If ite		20a. Method of Disposition 1 ② Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disponsion Cemetery, creating George W	ashing	ton ton	Cem.	6/1			ation - City or To lphi, Ma	
Bal	permit Depar Impor any Ir		21. Signature of Funeral Service Licenses Lonald	4	onald 400 Po	V. E wder	Borgwa Mil	ardt 1 Ro	Funera ad Belt	l Ho	me, PA le,Mary	land20705
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition resulting in death) a	ne. evoscleve a consequence of):					E		erse	Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and of for use as the burial-transit	ical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):								
O. Box 68	death certific e attending p ed for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic preg			-		23	Bd. Date of delive	ery Day Year
rds, P.	ires tha signed d be de	by	Part II. Other significant conditions contributing to death t	out not resulting in the u	nderlying cau	se giver	n in Part I.			bacco use		he cause of death?
al Record		Completed							24a. Was a autops perform	y .	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings available mpletion of cause of
on of Vital	ding Physician: Th h. After this certificate funeral director, pag	ion: To Be	25. Was case referred to medical examiner? Hospital: 1 Inpati 27. Manner of Death 1 Matural 5 Pending			Other	4 □ Nurs	sing Hon 2	(Check only on ne 5 Reside 8d. Describe he	ence 6	Other (Specif	(y)
Division	r Attenter deat irector:	ertification:		jury - At home, farm, str c. (Specify)			83 2 11		8f. Location (Si City or Town		Number or Rura	al Route Number,
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in	h occurred at vestigation, in	the time my opi	, date and nion, death	place, a	and due to the co	ause(s) a ate and p	and manner as s blace, and due to	tated. o the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier James K. Tryflefort	J. M.P		icense	326		2	9	signed (Month,	
	, :		30 Name and address of person who completed cause of James K. Lightfoot, Jr., M	.D. 7600 Ca	rroll	Ave	nue T	'akon	a Park,		W-1	
	Sta Regist		JUN 14 2005	rar's Signature	de							

		•	For State Registrar	State of Marylar		artment of H					
	Physici	an	1. Decedent's Name (First, Middle, Last) Waldtraut Veronica	Owens				2. Date of Deat Month	Day	Year 3. Time of I	2 3
	/Medic	al				4. Ch. Taur	1		2005 4c. County of	12:4	13 a
	Examin	er	4a. Facility Name (If not institution, give st 221 Booth Street			4b. City, Town, or Gaither:		ın			
	Francis		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Birth	Montgo		r Foreign
	Funeral Director			M 20%F 80	Yrs.	Months Days	Hours Min		1925	9. Birthplace (State or Country) Germany	r or orgr
	ס		Usual Residence of Decedent			1					
	nylan thow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City	
	Ba-f s	cto	Maryland Mon	ntgomery	Gai	thersburg	3			1 🗌 Yes	24_] NO
	with th	Director	10e. Street and Number	3+ 220D		10f. Zip Code	2070	1	0g. Citizen of W	hat Country?	
	s 23s		221 Booth Street,		10 101		0878	2	USA	A Indian	
326	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or liems 23a or 28a-f show raumatic event, the Medical Expresser must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	 Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates: 			Specify:	Specify Yes or No- rto Rican, etc.)	Black	- American Indian, c, White, etc. White	
Š	2 hou	ted	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Bu	siness/Industry	
2	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done o OO NOT use retired	iuring most of wo	orking			
2	od wit	Completed	12		Hom	emaker				Home	
2	be file tal Hy d oth	0	17. Father's Name (First, Middle, Last)					me (First, Middle, I	Maiden Sumame	e)	
Maryland 21215-0036	ould Men varke	ို	F.L. Topel					Frinda			
Ja	12 sh and r is rr		19a. Informant's Name/Relationship (Typ					lural Route Number			
o o	1 and Health em 2 ther 1		Eckehardt V. Herri 20a. Method of Disposition		and the same of th	sition (Name of	way, Mo			, MD 20886 City or Town, State	,
و	Pages nent of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cren	natory or other plac		July 11,			
Baltimore,	it. P.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			ational Cen		2005		on, Virgin	
B	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic eages.		1704 8 NO	onla	50	o Univers	collins sity Blv	d, W, Sil	Home In ver Spr.	c ing, MD 20	901
			23a. Parti. Enter the disease or complic shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	th. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Betw Onset and D	eath
	Physician /Medical		disease or condition resulting in death)	End Stage (Obstruct	rive Pur	monary Di	sease	20 year	
	Examiner			Due to (or as a consec	querice or,						
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Undergring Cause (Disease or injury	Due to (or as a consec	quence of):						
	cuted	Examiner	that initiated events C.								
20,	ate be executed physician and the burial-transit	Ë	resulting in death) Last	Due to (or as a consec	quence of):						
8760	cate be executed physician and the burial-transit	dicai	d.								
Box 6	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	al death 3□	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Y	'ear
o.	that the de led by the a detached	hysi	9 Unknown	9□ Unknown							
Vital Records, P	The law requires that the ste has been signed by the bage 2 should be detache	b	Part II. Other significant conditions conf	tributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.			bute to the cause of de	
ecc	has be	Completed						24a. Was a autops	y pi	ere autopsy findings a	available ause of
<u>~</u>		Con						perform 1 ☐ Yes		eath? □Yes 2□No	
ita I	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			104		ath (Check only on	e)		
0	Q 5.	10	1 Yes 2 No	1 Inpatient 2			4 Nursing	Home 5 Reside			
lon	ittending I death. ctor: After the funer	ation	1 Accident 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	Yes 2 □ No	200. Describe no	ow injury occurre	id.	
Division of	ial or Attend s after death al Director: , ad in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	r or Rural Route Numb	2ΘΓ ,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 (★ Certifying Physical Examination)	icien: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	n occurred at the tin restigation, in my o	ne, date and plac pinion, death occ	e, and due to the caurred at the time, d	ause(s) and mar ate and place, a	ner as stated. nd due to the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier	// /		29c. License	e number	2	9d. Date signed	(Month, Day, Year)	
	to		· Would	Musto		MD OO	52725		June 11	, 2005	
			30. Name and address of person who cor David Kristo, M.I				Washin	gton. DC	20307		
	Sta Registi		31. Date filed (Month, Day, Year) JUN 13 2005	₩ Registrar's Sign			"ADITIII	geom, De	20307	_	
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			For State Registrar	State of Maryla	•	artment of H		Mental Hy	giene Reg. No. 🗇	000	
			Decedent's Name (First, Middle, Last)				2. Date of De	ath	UU5	3. Time of Death
	Physici /Medi		Helen Levey (Opher				June	Day 7	2005	12:35 A ^M
	Examir		4a. Facility Name (If not institution, give	*		4b. City, Town, or	Location of Dea		4c. Co	unty of Death	1
			Chesapeake Woo	ds Center		Cambri			Do	rcheste	er
	Funeral		5. Social Security Number 6. Se	TM 2006	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	Cou	
	Director		215-16-5212 Usual Residence of Decedent	83	115.			July 12	1921	Mary	/land
	/land		10a. State 10b. County	10c. (City, Town or Lo	cation				-	10d. Inside City Limits
	Man a-fsh	tor	Maryland Dorches	ster (Cambridg	re					1 ☐ ¥es 2 ☐ No
	n the	Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ombi ruj	10f. Zip Code			10g. Citizer	of What Cou	ntry?
	th wil	aiD	525 Glenburn Ave	·		21613	3		USA		
	ems ems	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No to Rican, etc.))- 14.	Race - Ameri Black, White,	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:	. ,	Su	ecify:	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23a or 28a-f show event, I're Mydical Exandral, usi by nuffied at	d be	3 Widowed 4 □ Divorced	Year or Dates:	160 Door	dent's Usual Occupa	ation		105 Kind	B1a of Business/In	ack
15	in 72	Completed	15. Decedent's Edi (Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most of wa	orking		or Business/in	dustry
7		mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Crab	Picker	,		1		n/Kool Ice
	il Hygid other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle			
lar	Aental Aental rked c	To B	Joseph H. Stanle	2V			Julia	Nichol	s		
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, I		19a. Informant's Name/Relationship (T		19b. Maili	ng Address (Street a	and Number or R	ural Route Numb	er, City or T	own, State, Zip	Code)
	ges 1 and 2 should it of Health and Men If item 27 Is marke or other traumatic		Geraldine Macer					TATE OF THE PERSON OF THE PERS	alsbu	rg,Mary	yland 21632
ore	of H of H if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	20b Removal from State	. Place of Dispo cemetery, crea	sition (Name of matory or other place	e)	Date	20c. Local	tion - City or To	own, State
Ë	Pages Iment of I tant: If it		`4 ☐ Donation 5 ☐ Other (Specify,	Mt		sant Cem.		1-2005		m,Maryl	Land
Baltimore	permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other trau		21. Signature of Funeral Service Licens	99	2	Bennie Sr	ss of Facility nith Fun	eral Hon	ne	27 32	01610
			23a. Part1. Enter the disease, or comp	lications that caused the de	ath. Do not en	524 Kace				ryland_	Z1613 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.		1000	ار اس	o or roop.ratory o			Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a Oue to (or as a cons	150n5	DISEC	156				years
	Examiner			500 to (61 a3 a cons	equerice or).)
		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying	b. Due to (or as a cons	equence of):						
	recuted and I-transi	Examiner	that initiated events	c							
0	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as a cons	equence of):						
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9	entific fing p	Med	IF FEMALE:	201 14							
Box	leath certific attending p	ian	230. Was decedent pregnant	23c. If yes, outcome of pred 1□Live birth 2□Fe	etal death 3	Ectopic pregnancy			230	 Date of deliver Month 	ery Day Year
P.0.	res that the de signed by the a be detached f	Physician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	ideath 5L	Other (specify)					
	that t ed by detai	/Ph	Part II, Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
ds	uires I sign Id be	d by	Sepsis Ke	nal failu	re K	habdom	unlusi	5 10	Yes 2□1	√o 3 ☐ Prot	pably 4 Unknown
Records,	w requ been should	Completed	Dichotos N	1011, tus	Alzhei	, >		24a. Was	an 2	24h Were auto	ppsy findings available
Re	iclen: The lav certificate has rector, page 2	mc	is inverse	CITIED, 1	112/101	11013 1	Jemen+	auto perfe	psy ormed?	prior to co death?	mpletion of cause of
tal	ifficat or, pa	Be Co	25. Was case referred to medical				26 Place of De	1 ☐ Yes	2 X No	1 🗆 Yes	No No
of Vital	Physicien: this certificaral director, i	To B	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	00	Home 5 Resi		Other (Specia	(v)
0	ding Phys After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		y at	28d. Describe			,,
Ö	uttendin death. ctor: Af y the fur	atic	1 Natural 5 Pending investigation		III, G. Y		Yes 2 □ No				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, larm, st cify)	reet, factory, office		28f. Location (City or To	Street and N wn, State)	lumber or Run	al Route Number,
	To the Hospitel or Attending Physicien: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should		000 Codilion 150 Com					ļi			
	24 ho 24 ho Fune	Medicai	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of my kiner: Omthe basis of exami	nowledge, deat ination and/or in	n occurred at the tim vestigation, in my op	ne, date and plac pinion, death occ	e, and due to the urred at the time,	date and pla	d manner as s ace, and due to	stated. the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	/ Stated.		29c. License	e number		29d. Date s	igned (Month,	Day, Year)
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	(3)		LLOIS A	Narr T	D.O.	100 Br	amb/	e 5t.	Can	nbrid	ge MD
	St	ate	31. Date filed (Month, Day, Year)	32 egistrar's Sig	nature	9					J - /

		-	For State	State of M	arylan			nt of He <i>te of E</i>		ınd Me		-		
			Registrar 1. Decedent's Name (First, Middle, Las	t)			imoa	10 01 L	Jeann	2	2. Date of De	Reg. No.	005	3. Time of Death
	Physicia	an		ersoll	Ohea	rn					Month	Day		9;15 A ^M
	/Medic						4h Cih	Town or	1 continu		June		County of Death	9;13 A
	Examin	er	4a. Facility Name (If not institution, give					, Town, or		Death				
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	Funeral		5. Social Security Number 6. So	x □M 2/10 F /. A		last birthday) Yrs.	Months		Hours	Min.	Month, Da	y, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director	-	218-32-5568 Usual Residence of Decedent		69			1		JM.	larch 2	1,19.	36 Wash	ington,DC
	and w	-	10a. Slate 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
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	M or	늅	5748 Woodville	Dood			101.2		1					
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	ttem them	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	10.1	f Yes, sp	ecify Cubar	n, Mexican	, Puerto Ri	ican, etc.)		Black, White,	
9500-61212	hours after death with the Maryland ural', or tems 23a or 28a-f show at Examiner houst be notified at	by	3 November 1 Divorced	If Yes, Give Year or Dates		1	I □ Yes	No No	Specify:				Specify: Wh	ite
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0	Hyg Hyg Snt,	0	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (First, Middle,			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. Inpartment I firem 27 is marked other than "natural", or items 28 or 28a-1 show any injury or other traumatic event, the Madical Examiter is that be institled at once.	To Be	Pau1	W	atts			Ì	Во	nnie			Tubbs	
₹	should and Men marke umarke	-	19a. Informant's Name/Relationship (19b. Mailin	g Addre	ss (Street a			Route Numbe	er, City or	Town, State, Zi	c Code)
<u>8</u>	trau		Bonnie M. O'Hearn	ı / Daugh	ter	1042	S.	Irony	book	Rd /	Sterl	ino	VA	20164
a)	1 an Heal Heal Heal	ŀ	20a. Method of Disposition	- /	20b. P	lace of Dispo	sition (N	ame of		Dai			cation - City or T	
ဋ	Pages nent of I int: If It iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		е	emetery, cren ederick				6/10/	2005	T2 J	1 M	1
Baltimore,	permit. Page Department Important: If any injury o	}	21. Signature of Funeral Service Licen	·	1110							rrea	lerick,M al Home	aryiand
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			23a. Part1 Enter the disease, or com	plications that cause	ed the deat	h Do not ent	E. I	xlager	VIIIE	BTAG	respiratory a	int A	iry, MD	21771 Approximate
	- 10		shopk or heart failure. List only	one cause on each	line.									Interval Between Onset and Death
ı	hysician		Immediate Cause (Final disease or condition resulting in death)	a. 37	nos/	1 1	ou	, = /	0	bst	-uct	40	2	701
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×		/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	ancv							2d Data of dalis	254
. Box	death certiff e attending id for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	Ideath 3	Ectopic Other (pregnancy				1	3d. Date of deliv Month	Day Year
o.	the d	Physician/M	1 ☐ Yes 2 ☐ To 9 ☐ Unknown	9 Unknown		batii 5	J Ottier (specify/						
<u>a.</u>	es that the death certif gned by the attending be detached for use at	P	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
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\leq	hysl his c	ျ	1 Yes 2 10	Hospital: 1 Inpa		ER/Outpatien			4 🗆 Nu				Other (Speci	fy)
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<u>S</u>	sndi eath. or: A	catl	Accident investigation				М		/es 2 □ I					
Division of Vital Records,	Irect Irect	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289. Place of I	Injury - At ho etc. <i>(Specit</i>		eet, facto	ory, office		28	If. Location (: City or To			al Route Number,
۵	rital c													
	Hosp 4 hou Fune ely fil	edical	(Check only 2 Medical Exer	ysician: To the bearing the basis	of examina	wiedge, death ition and/or in	n occurre vestigation	d at the tim on, in my op	e, date and pinion, dea	d place, an th occurrec	d due to the at the time,	cause(s) date and	and manner as a place, and due to	stated. o the cause(s)
	To the Hospital or Attanding Physician: The law requires that the within 24 hours attendeath. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medi	one)	and manner	stated.								e signed (Month,	
	Vill Vill Con	2	29b. Signature and title of certifier	7/			2	9c. License						
				- Land	47			PI	46 5	2		Ju.	72 9	2005
	- [. 1	30. Name and address of person who	completed cause of	f death (Item	n 23a) (Type	Deleta							
	7						Print)		59 -	,		11	- 4-	1 11
	Sta			Usch M		501	Print)	, 76	59 50	<	Fre	de	red M	2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** VINCENT PRATHER THOMAS 1:55 PM 10,2005 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 9505 Lindale Drive Bethesda If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 53 214-60-6911 Apr.17,1952 Wash. Director DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. or hant: If item 27 is marked other then "natural", or Items 23a or 28e-f show forjant: If item 27 is marked other then "natural", or other traumetic event, the Marical Examiner must be notified at a second process. 1 XYes 2 No Dickerson Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20842 20915 Big Woods Dr 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☑ No Specify: Specify: Š 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Retail Store Keeper 2vears 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Prather Rachael Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20915 Big Woods Dr. Dickerson, MD 20842 Sandra M. Prather-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page
Department of
Important: If
any injury or 6/17/05 Frederick, MD * 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Cem. 22. Name and Address of Facility Snowden Funeral Home, P.A. gnature of Funeral Service License 1246 N. Washington St, Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherasclerotic **Physician** /Medical Due to (or as a consequence of): Examiner idbeteg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 2 No 2 X No 1 Yes or Attending Physician: 25. Was case referred to medical examiner?

1 X Yes 2 □ No Be 26. Place of Death (Check only one) 6 Other (Specify) Be indale, Di Hospital: Other: 4 Nursing Home 5 Residence 1 🗆 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification; 1 Natural 2 Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Fo the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier articia 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Pike oms atricia 31. Date filed (Month, Day, Year) Registrar's Signature State 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 6:45P M 8, 2005 Dell June Peel Virginia /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery HCR Manor Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June27, 1916 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 □ M 21 F 88 Yrs. Elmira, NewYork 213-40-5395 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 28e-f show other traumatic avent, the Medical Examiner must be nutified at 1 Yes 2 No Prince George's Beltsville Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20705 United States 11028 Montgomery Road or items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Goodwin Grace L. Webb Earl 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ont of Health and ortant: If item 27 la revy injury or other 17 11028 Montgomery Road Beltsville, Maryland 20705 Virginia Bray -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: if any injury or once. Gate of Heaven Cemetery 6/13/2005 Silver Spring, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 minutes Physician Cardiac Arrest /Medical Due to (or as a consequence of months Electrolyte Imbalance **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Renal Failure years physician and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE: use 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Day Month in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant at time of death P.O. I the 9 Unknown 9 Unknow à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ anaemia; hypertension; dementia 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No 26 Place of Death Check onlone 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 XNo this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Hospital or Attanding I 24 hours after death.
Funeral Diractor: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie o the hu within 2/ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 10, 2005 Marin

Registrar

State

Raman R. Tuli, M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 Darnestown Rd., #202 Gaithersburg, Maryland 20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 🤈 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav **Physician** Year 12 John Mike1 2005 10:24 A June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov • 17, 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Mary land 218-38-6429 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits set be notified at Montgomery Gaithersburg Md. 1 ☐ Yes 2X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8626 Oakmont Street 20877 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or Items 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1962-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 1965 "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Small Business Owner Self-Employed other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nd 2 should be fi lith and Mental H 27 Is marked ot r traumatic ever permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury of other traumatic evones. Jean C. Pack Emma Alberta Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8626 Oakmont Street Gaithersburg, Md. 20877 Valerie DeJar1d (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 TCremation 3 Removal from State
4 Donation 5 Other (Specify) June 16, Metropolitan Crem. Alexandria, Va. 2005 21. Signature of Funeral Service Licentum & . K 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction Seconds /Medical Due to (or as a consequence of) **Examiner** Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. 9 Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 1 Yes 2 XNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I miea? 2X No certificate 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 70 1 Inpatient 2 XER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) To +1 D0031058 June 14, 2005 lu MI 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene Ashe, M.D. 10200 Coppermine Road Woodsboro, Maryland 21798

DHMH 17 Rev 1/2001

Registra

31. Date filed (Month, Day, Year) JUN

15 2005

			1 - For State	State of Maryl	and / Depa		lealth and M	Mental Hyg	200	. 01000
			Registrar 1. Decedent's Name (First, Middle, La	ot)		C /	Dealli	2. Date of Deat	g. No.) < (11511
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7	Examir	ner	4a. Fecility Name (If not institution, giv		\		r Location of Death	_	4c. County of De	A th
			26148 Viel)Y		95CU.		mon	-bornerh
	Funeral		5. Social Security Number 6. S	TH ONE	vrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		Country)
	Director	ļ	469-24-40/3	77	115.			Sept. 2	6, 1927	Minnesota
	and *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	lanyl sho	5	Maryland Montgor							1 ☐ Yes 2 🔀 No
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	with a or	급				10f. Zip Code		1"	0g. Citizen of What (country?
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	er de	une	11. Marital Status	12. Wes Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	s aft	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give		1□Yes 2Ñ No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or items 23a or 28e-f show the Madical Examiner must be notified at	P	N = 1000	Year or Dates:	10.0					
5	"naf	ete	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ring	16b. Kind of Busines	s/industry
12	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		countant	1)		D-41	
2	be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "natural", or items 23a or 28e-f show event. The Madical Examiner must be notified at		17. Father's Name (First, Middle, Last)		AC	councaire	18. Mother's Nam	o /First Middle A		Government
anc	should be filed withir of Mental Hygiene. marked other then matic event, the Mental country of the Mental coun	Be	Michael Joseph 1						iaiden Sumame)	
Ž	should Ind Men	2			401 14:35		Susan To			
Maryland	12 sho h and 7 ls m treum		19a. Informant's Name/Relationship (-					City or Town, State,	
	of Health Item 27 Other tr		John F. Conlon/ 20a. Method of Disposition						MD 208	
ō	S = S		1 Burial 2 ☐ Cremation 3 ☐			sition (Name of natory or other place	J 0 0.1.	e 15,	20c. Location - City of	r Iown, State
Ë	nit. Pages 1 and 2 should artment of Health and Men ortent: If Item 27 Is marke injury or other treumatic		* 4 □Donation 5 □ Other (Specify			aven Cemete				ing,Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licer	Isee /	F.	Name and Address J.	ss of Facility.	Funeral	Home Inc	
ш_	20E = 9		Thu & sc	eres	50	00 Univer	sity Blv	d, W, Si	lver Sprin	ng, MD 20901
			23a. Part. Enter the disease or com shock, or hear failure. List only	plications that caused the done cause on each line.	eeth. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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õ	ng ph ng ph as ti	Physician/Med	IF FEMALE:							
Box	eath certific attending pl	30	23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnancy			23d. Date of de	
	the att	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Other (specify)			Month	Day Year
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	es iha igned be dei	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
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သို့	e law re has be je 2 sho	ple						24a. Was an		utopsy findings available
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o of	Attending Physicien: r death. ector: After this certific by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injury Work	at	28d. Describe how		
<u>Ö</u>	uttending I death. ctor: After y the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation) Injury		Yes 2 □ No			
Division	Atte	9	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Injury - A	t home, farm, stre	eet, factory, office			eet and Number or F	ural Route Number,
ā	el or Att s after d el Direct ed in by	Certification:	· I · I · I · I · I · I · I · I · I · I	building, etc. (Spe	еспу)			City or Town,	State)	
	Hospitel		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, death	occurred at the tim	e, date and place,	and due to the car	use(s) and manner a	s stated.
	the H hin 24 the Fi	edical	one) 220 medical exam	niner: On the basis of exam and margner stated.	ination and/or inv	estigation, in my op	oinion, death occurr	ed at the time, da	te and place, and du	e to the cause(s)
	To the Hospitel or visitin 24 hours after To the Funerel Directorpletely filled in b	Σ	29b Signature and title of certifier	//		29c. License		29	d. Date signed (Mon	/
)	10		graphe	eckirms	DME	100	0428	. 3	Tun 9,	2005
	10		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print) 21	or me	treat	Park	or
			2KH NIBR	ECHER, 1	no on	DE SI	Ive , c	112412	Park L	20902
rps);	Sta	-	31. Date filed (Month, Day, Year)	Registrar's Sign	nature A	Mi)		1	1	
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		•	For State Registrar			nd / Depa		of H	ealth a		ental Hyg		0.05	21061
	Physici	an	Decedent's Name (First, Middle								2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	al	Dixie Lee Pugh				45 675 7	- 1/4		(D)	June	6,	2005	11:38 a M
	Examin	er	4a. Fecility Name (If not institution 452 Man O War		moer)				Location o	or Death			nty of Death	ndol
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under	1 Year	If Under		8. Date of Birtl	1	ne Aru	Place (State or Foreign htry)
	Director		218-62-4739 Usual Residence of Decedent	1 □ M 2 🛣 F	51		Months	Days	Hours	Min.	(Month, Day Aug. 8	1953	Cour	MD MD
	Marylen e-f show	ctor	MD 10b. County Anne	Arundel	10c. (City, Town or Lo	Annap	olis	5				1	0d. Inside City Limits 1 ☐ Yes 2 X No
	with th	Dire	10e. Street and Number	G			10f. Zip		14			10g. Citizen	of What Cour	
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336	72 hours after death with the Marylend Insturet; or Items 23s or 28s-1 show disal Exactinat must be notitied at	by Fun	1 ☐ Never Married 2⊠ Marriad 3 ☐ Widowed 4 ☐ Divorced	ried Armed F	orces? 2 ∑ No ive		If Yes, speci 1 ☐ Yes 2			, Puerto	ecify Yes or No- Rican, etc.)		lack, White,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Deperment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinating the notified at once.	Completed by Funeral Director	15. Deceden (Specify only highe Elementary/Secondary (0-12) 12	nt's Education st grade completed) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use eacher	k done d e retired;	uring mos		ng		Business/In	
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ylan	ould be Mental sarked satic ev	To Be	Walter Eugene								ee Dunla			
Mar	d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relations Ellis L. Pugh		band						Annone			
Baltimore,	es 1 an of Heal if item 2 or other	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b.	Place of Dispo	sition (Nam	e of her place	9)		Annapo:	20c. Locatio	n - City or To	own, State
Ħ,	it. Pag rtment rtant: njury c		`4 □Donation 5 □Other (S	Specify)	6	Slen Hav					2005	Glen	Burnie	, MD
Ba	Depending on it		21. Signature of Funeral Service	Zu		- E	arran Barran 195 Go	CO 8	Son	s. P.	.A. Seve	erna P	ark Fu ark. M	neral Home D 21146
4	Amount of the private	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a conse	equence of):	NCE	<u>ر</u>						Onset and Death
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ς, σ	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ons contributing to o	death but not re	esulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	1		ne cause of death? ably 4 □Unknown
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ō	g Phy er this ieral d	n; To	27. Manner of Death	28a. Date		ER/Outpatier		Bc. Injury Work	at		ne 5 A Hesia 28d. Describe h		Other <i>(Specif</i>) curred	/)
Sior	Attending ir death. ector: After by the fune	atlo	1 Natural 5 Pendir 2 Accident investi	gation	nin, Day rear	Injury	М		es 2 □ I	No				
Division	after d after d Direct d in by	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289, Plac	e of Injury - At ling, etc. (Spec	home, farm, str cify)	eet, factory,	office		2	28f. Location (S City or Tow		mber or Rura	l Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after deals after this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physicien: To th Examiner: On the l and man	e best of my k basis of exami oner stated.	nowledge, deat nation and/or in	n occurred a vestigation,	it the tim in my op	e, date an	d place, a	and due to the co	ause(s) and late and plac	manner as st e, and due to	ated. the cause(s)
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			30. Name and address of person											
	Sta	te	William Dabbs 31. Date filed (Month, Day, Year)	32.	egistrar's Sig	insula	rarm F	KOad	, Arn	old,	MD 21	012		1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	arytand / Depa <i>Cel</i>	artment of F rtificate of			g. No.		
			Decedent's Name (First, Middle, La	ast)				2. Date of Death		3. Time of Death	
	Physicia /Medic		Arthea Joyce POW					June 12	2005	12:15 a.M	
	Examin	er	4a. Facility Name (If not institution, gi				or Location of Death		4c. County of Dea		
			Homewood at Will 5. Social Security Number 6.	<u> </u>	(In yrs. last birthday)	If Under 1 Year	Villiamspo	8. Date of Birth	Washin		
	Funeral Director	- 1		1□M 2፟XF	67 Yrs.	Months Days	Hours Min.	Nov. 7,	1937 Ka	rthplace (State or Foreign ountry) Ansas	
	/land	1	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
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	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?	
	s 23s	iai	13502 Paradise		Tunna in II C		L740		USA 14. Race - Am	oriona todion	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic avant, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	lo	was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi		
2-0	72 ho	eted	15. Decedent's 8 (Specify only highest gi	ducation	16a. Dece	dent's Usual Occup	pation during most of work d)	ina 1	6b. Kind of Business	/Industry	
21	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire a entry	d)		redit car	d company	
2	be filed v tal Hygie d othar t avant, th		12 17. Father's Name (First, Middle, Las	0	uat	a entry	18. Mother's Name			d company	
auc	id be in a second of the secon	To Be	Arthur A. Watso					Hazel Tr			
ary	should and Men s marka umatic	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number,	City or Town, State,	Zip Code)	
	and 2		Glenda D. Hammon	d – daught				, Mercer	sburg, Pa	. 17236	
Baltimore,	Pages 1		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 [☐Removal from State	20b. Place of Dispo cemetery, crer				Oc. Location - City or		
ţ	t. Pag ntmen rtant: njury		'4 □Donation 5 □ Other (Spec				Park 6/15/			, Maryland	
Bal	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lice	Mun		2. Name and Addre			I FUNERAL stown, Md.		
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent ie.	er the mode of dying	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Priset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a (91	(OBUAS)	and V	MUTIF	MME		370 Y	
	/Medical Examiner	Due to (or as a consequence of):									
		Jer	Sequentially list conditions, if any, leading to immediate	b	a consequence of):						
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
60,	tificate be executed by physician and as the burial-transit	Ĕ.	resulting in death) Last	Due to (or as	a consequence of):						
68760,	tificate ig physias the	edicai	•	d	_						
.O. Box	that the death certined by the attending detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of de Month	livery Day Year	
Δ.	res that igned by be deta	by Pr	Part II. Other significant conditions	contributing to death be	ut not resulting in the u	nderlying cause giv	ren in Part I.	_		the cause of death?	
ord	w requir been si should	eted					-	1 ☐ Yes	s 2□No 3□P	robably 4 Unknown	
al Records,	The lar ate has page 2	Completed						24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of	
Vital	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner?	Hospital:		ott	26. Place of Death				
of	ding Phys	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		28c. Injur	y at	me 5 Hesider 28d. Describe hov	nce 6 Other (Spe w injury occurred	icity)	
ion	Attending r death. actor: After by the fune	atio	1 Natural 5 ☐ Pending 2 Accident investigation	on	(Year) Injury	M 1 🗆	Yes 2 No				
Division	after de Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not determined		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Street) City or Town,	eet and Number or R State)	ural Route Number,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C		hysician: To the best of miner: On the basis of and manner sta	examination and/or in						
	To tha within 2 To tha complet	Med	29b. Signature And/title of dertifier	/4	\	29c. Liceos	e number	29	d. Daye signed (Mont	th, Day, Year)	
	25		D 11/2	Mos	(or Marce	Tan	0/706		Veu= 1	3,2005	
	7		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Prigt) V()A	THOUN !	for	HAGUI	TORON,	
			31. Date filed (Month, Day, Year)	32 Banietes	ar's Signature			1	1.1		

State of Maryland / Department of Health and Mental Hygiene

Physicia	an	Decedent's Name (First, Middle, Last			DOT ANGES	7	2. Date of Dea Month	Day Ye	3. Time of Death		
/Medic		MILDRED	M		POLANSKY		June	7, 2005			
Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County of E			
		Homewood At Crui 5. Social Security Number 6. S		la at hirthday	Frede	rick If Under 24 Hrs.	8. Date of Birt	Frede			
uneral irector			© M 221 F 86	Yrs.	Months Days	Hours Min.	April 1	y, Year)	Birthplace (State or Foreig Country) Pennsylvania		
a-f show	ctor	10a. State 10b. County	derick 10c. Cit	y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
23c or 28	al Director	10e. Street and Number 7407 Willow Road			10f. Zip Code 2170)2		10g. Citizen of Wha United	States		
r result and weather trygeler a partie of teams 23s or 28s-f show tien 27 is marked other than "naturel", or items 23s or 28s-f show other treumetic event, the Modical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates;		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, Vhite, etc. Vhite		
*nature	leted	15. Decedent's Ed (Specify only highest gra	ducation	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work.	ing	16b. Kind of Busin			
and mental hyglene. Is marked other than eumetic event, the M.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker			own	home		
rked oth	To Be	17. Father's Name (First, Middle, Last) Michael	Fritz			18. Mother's Name	e (First, Middle,	Maiden Sumame) Sabol			
n ma		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Numbe	er, City or Town, Sta	te, Zip Code)		
item 27 ls		Walter M. Polans			Deer Hol	low Dr./	Mount A		21771		
Importent: If ite any injury or of once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crei	matory`or other plac	(8)		Frederic	k,Maryland		
Import any inj once.		21. Signature of Funeral Service Licer	nsee	1 1000				uneral Ho	omes, P.A.		
/sician ledical aminer		23a. Part I En of the disease, or o'm shock of feart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line. a. Due to (or as a conseq	h. Do not en	er the mode of dyin		or respiratory ar		Approximate Interval Between Onset and Death		
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sician and burial-tra		that initiated events c. That initiated events c. Due to (or as a consequence of):									
nding phy use as the	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna			-		23d. Date of	delivery		
y the atte	Physiclan	in the past 12 months2 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	1□Live birth 2 □Feta 4□Pregnant at time of d 9□Unknown		∐Ectopic pregnancy ☐ Other (s <i>pecify)</i>			Month	Day Year		
been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		te to the cause of death? Probably 4 Unknow		
has le 2	Completed		.					sy prior deat	e autopsy findings availab to completion of cause of h? Yes 2 \(\subseteq \text{No} \)		
is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	n (Check only o	ne)			
e D	P.	1 ☐ Yes 2 ☐ HO	Hospital: 1 Inpatient 2			4 Hoursing Ho		lence 6 Other (Specify)		
r: After ne funer	atlon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred			
To the Funeral Director: Atter the completely filled in by the funeral	Certification:	3 Suicide 6 Could not b		ome, farm, sti	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,		
e Suner letely fille	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and mampr stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the deed at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)		
To th comp	Me	29b. Signature and fittle of certifier	Manto	Lle	29c. Licens	3/7/2 3	,	29d. Date signed (M			
8		30. Name and address of per or mo	com, ted cause of death (Iten	23a) (Type,	Print)	57155 - 18H -	4	June,	1,2005		
Sta	ate :	31. Date filed (Month, Day, Year)	2005 32. Si gistrar's Signa	iture	had s	7145	7	oger	100		

		•	For State Registrar	State of M	aryland .		irtment of F		and Men		iene	05	2106
			Decedent's Name (First, Middle, L	ast)						Date of Deat		V	3. Time of Death
	Physicia /Medic		CHARLES WESLEY	PECK						ine 8,	,	Year	7:20 p M
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location o	of Death		4c. County	of Death	•
	*		3802 Nicholson				Hyattsvi		24 1172				orge's
п	Funeral		5. Social Security Number 6. 579-40-7662	Sex 7. Ag	e (In yrs. last 73	Yrs.	Months Days	Hours	Min. Fel	Date of Birth Month, Day, D. 28,	Year)	9. Birthr	place (State or Foreign
	Director		Usual Residence of Decedent		,,,			1	Tel	0. 20,	1932	Was	hington, DC
	yland		10a. State 10b. County		10c. City, T	own or Lo	cation			_		1	0d. Inside City Limits
	Ba-f s	ctor	DC		Washi	ngto	n, DC						1 No 2 No
	or 28	Director	10e. Street and Number				10f, Zip Code			1	0g. Citizen of	What Cour	ntry?
	s 23a		50 Franklin Str		5	1.0	20002		10/0		U.S.A.		
	ltem nerr	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 X Yes 2 []		13. \	Was Decedent of H f Yes, specify Cuba	an, Mexican	gin? (Specify n, Puerto Rica	n, etc.)		ce - Americ ck, White,	
336	ars aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 2█No	Specify:			Specif	y: Whi	te
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N	ygien ygien yer th			2		U.S.	Postal S				U.S. Go		ment
Maryland	be fill ad ott	Be	17. Father's Name (First, Middle, La								Maiden Sumar L	<i>π</i> ⊖)	
ž	hould d Mei mark matic	To	Charles W. Peck 19a. Informant's Name/Relationship			19h Mailir	na Address (Street		ce Elle			State Zir	Code)
Z	treu		Barbara J. Marm				Monroe Ma						,
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene 1 hours at them 23a or 28a-f show them 27 is marked other then "neture!, or flems 23a or 28a-f show other treumatic svent, its Medical Examinar must be notified at	1	20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other place		Date		20c. Location		
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Baltimore,	permit. Pages Department of Importent: If I any injury or once.		21. Signatur of Funeral Service Lice	enseę		22	. Name and Addre						
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	/Medical Examiner		resuming in deathy	Due to (or as	a consequer	nce of):							
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	ertifica ling pla e as t		IF FEMALE:										
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Re	o - o	Completed								autops perform	med? 2 X No	death?	2 No
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of V	Physicien: this certificand director,	2	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpat		VOutpatie	IL 3U DOA		7		ence 6 ∑ Otl		WResidence
u C	fter	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28 ay Year)	Bb. Time o Injury	Wo	ryat rk?]Yes 2. □		Describe he	ow injury occu	rred	
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Di	E Sign	Certification:	4 ☐ Homicide determin	building, e	tc. (Specify)	,,	, , , , , , , , , , , , , , , , , , , ,			City or Town			
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	To To To	2	29b. Signature and title of certifier	ar he h	×		29c. Licens			2	9d. Date signe	,	,
	1		M	of the	10		D14	/ 30	-		June	10, 2	.005
0	R 12)	1	30. Name and address of person w Kai-Yiu Yeung,				Print) d, Suite	201	Clint	on Mr	20725		
	St	ate	31. Date filed (Month, Day, Year)	₽. Regis	trar's Signatur	re		2019	OTTILL	OII, PIL	, 20133		
	Regist		JUN 1 0 20	05 Kenne	, #	April	le le						

		1 _ State	State of Maryla		rtment of He			2	nns.	21965
		Registrar 1. Decedent's Name (First, Middle, Last)		007	inodic or D	Catri	2. Date of Dea	Reg. Nó ith	000	3. Time of Death
Physic		JAMES IRVIN PERRY	Y				Month	Day	2005	0000
/Medi Examii		4a. Facility Name (If not institution, give si			4b. City, Town, or Lo	ocation of Death	June	4c. C	ounty of Death	
		Memorial Ho	spital		Cumb	erlani	d	$\perp A$	llega	nlx
Funeral		5. Social Security Number 6. Sex	M OFF	s. last birthday)		Hours Min.	8. Date of Birth (Month, Day	, Year)	(9) Birth	oplace (State or Foreign
Director		Usual Residence of Decedent	76	Yrs.			MAY 1 19	929	MAR	YLAND
land		10a. State 10b. County	10c. (City, Town or Loc	ation					10d. Inside City Limits
Mary -1 sh	ţō	MARYLAND ALLEGANY	FR	OSTBURG						1 ☐ Yes 2 🛣 No
h the	Director	10e. Street and Number	, 11	OD I DO I I O	10f. Zip Code			10g. Citize	n of What Co	untry?
th wit	alD	100 FROST VILLAG	E		21532			U.S	S	
r dea	Funeral		2. Was Decedent Ever in Armed Forces?	U.S. 13. W	/as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	Race - Amer Black, White	
s afte	by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 ∐ Xi o If Yes, Give			Specify:	·			HITE
hour tural	ed b	15. Decedent's Educ	Year or Dates:	16a Decede	ent's Usual Occupation	On		16h King	f of Business/l	ndustri
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be filed within 72 hours after death with the Maryland lat Hyglene. d other than "natural", or items 23s or 28s-1 show event, the Medical Examinat must be notified at	Be	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	(First, Middle,	Maiden S	umame)	
should to marked umatic e	2	JAMES WILBUR PER	RY				WEBSTER			
4 to tre		19a. Informant's Name/Relationship (Type CHARLES PERRY /	•		Address (Street and MELLO AVI					ip Code)
of Hea		20a. Method of Disposition 1 □ Burial 2 □ © remation 3 □ Re		. Place of Dispos cemetery, crem	ition (Name of atory or other place)		Date	20c. Loca	ation - City or T	Town, State
mit. Pages partment of I portant: If it y injury or o		`4 □Donation 5 □ Other (Specify)	CU	MBERLAN	D CREMATOR	RY 6/20	/05 (ERLAND,	
partillore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other page.		21. Signature of Euneral Service License	7. Sowers	/	Name and Address WERS FUNE		, P.A.		. MAIN TBURG,	ST. MD 21532
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the de e cause on each line.	ath. Do not ente	r the mode of dying,	such as cardiac o	or respiratory arr	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Clockso	ovascul	au c	xceida	nt			Onset and Death
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The law requires that the death certificate hes been signed by the attending to age 2 should be detached for use as	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown	f death 5	Other (specify)				WIGHT	Day 16al
that the ed by detac		Part II. Other significant conditions con	tributing to death but not re	esulting in the un-	derlying cause given	in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
w requires been signi	ed by						1 🗆 Y	es 2	No 3□Pro	bably 4 Unknown
aw requir s been si	Completed						24a. Was a		24b. Were aut	opsy findings available
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VICAL MEC siclen: The law s certificate hes b lirector, page 2 s	Be	25. Was case referred to medical examiner?			2	26. Place of Death				
Physic this co	은	1 ☐ Yes 2 🛣 No		☐ ER/Outpatient		4 Nursing Ho	me 5 Resid	ence 6	□Other (Spec	ify)
nding P ath. r: After I	ertification;	27. Manner of Death 12 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe h	ow injury	occurred	
ttend death ctor:	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm etro		s 2 No	28f Location (S	treet and	Number or Ru	ral Route Number,
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To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 15 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my killer: On the basis of examiliand manner stated.	nowledge, death nation and/or inve	occurred at the time, estigation, in my opin	date and place, and income death occurred	and due to the c ed at the time, d	ause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
To th withir To th comp	₩ W	29b. Signature and title of certifier			29c. License n	number	2	29d. Date	signed (Month	, Day, Year)
		1 Alexander			D006	0478		612	20105	
`\		30. Name and address of person who cor	npleted cause of death (It	em 23a) (Type, F	Print)		1001-	4	10 0	
\ \	ate	31. Date filed (Month, Par, Year)	32. Hegistrar's Sig	nature	Hvenue	Cur	nderlar	na, p	IID al	502
Regist		JUN 2 4 20	32. Hegistrar's Sign	15 A	will					

unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene

Registrar

Registrar Diana L. Pessaro)5-04105 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** June 15, 7:52 PT ... Diana Lynn Pessaro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel County North Arundel Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2X F Days Hours Yrs Director 214-66-4835 48 9-17-1956 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Exempres must be inclified at Anne Arundel Maryland Pasadena 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7855 Flintshire Ct. 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be ind Mental and Mental Joseph Maclane Connell, Sr. Shirley Ann Hammer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nt of Health a 7855 Flintshire Ct., Pasadena, MD 21122 Earl N. Pessaro, Jr./ Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ŏ permit. Page Department of Important: if any injury or once. St. Mary's Cemetery 6-20-05 Annapolis, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mixed Drug Intoxication (Methadore, Citalopran, Quetiapine) disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-translt Due to (or as a consequence of): Box 68760. Physician/Medical the 25 attending use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ŏ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 leath? Yes 2 🗆 No 1 XYes 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∑Yes 2□No Certification: To æ 27. Manner of Death Par Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After the funer 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 📉 No 6/15/2005 7:12 P M 2 Accident 6X Could not be within 24 hours after de To the Funeral Directo completely filled in by th 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7855 Flintshire Court determined 4 🗌 Homicide ŏ Found at residence To the Hospital Pasadena, Maryland 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) June 16, 2005 29b. Signature and title of certifier 29c. License number OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			1. Decedent's Name (First, Middle, La	ist)							2. Date of De	eath Da		J	3. Time of Dea	ith
	Physici: /Medic		Ruby Cat	herine	Ç	Quinn					June			ear	9:35 P	M
	Examin		4a. Facility Name (If not institution, given	e street and number)			4b. City, To	own, or	Location o	of Death		4c	. County of	Death		
			510 Carroll Ave	nue			Mt	. A:	iry				Car	rol	L	
	Funeral Director		225-24-7158	Sex 7. Age	(In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Bi (Month, D April 2	th ay Year) 24, I	924	Birthp Coun V1:	lace (State or Fo try) rginia	reign
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City Li	mits	
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Mar	parmit. Pages 1 and 2 should be liad within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If tem 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a Modical Examinar is use the notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Caroline and Number of Rural Route Number								_					
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	,		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,	Print)									
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Baitimore,	permit. Pages 1 and 2 should be to Department of Health and Mental Himportant: If item 27 is marked of eny injuryor other treumatic events.		21. Signature of Funeral Service Lic		4.	H.	Name and Addre	ss of Facility						
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,	Physician		HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bean failure. List only one cause on each line. Immediate Cause (Final disease or condition End Stay Chronic Oh Shuller and Death Onset and Death of the condition of the state of the condition of the state of the condition of the state of the condition of the state of the state of the condition of the state of the condition of the state											
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DIVISION	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
_	hours a nerei D		29a. Certifier 1 Certifying	Physician: To th	ne best of my kno	owledge, death	occurred at the tir	ne, date and pla	ace, and due to the ca	use(s) and ma	anner as st	ated.		
	the Hohin 24 the Foundation	Medical	one)	aminer: On the and ma	nner stated.	ation and/or in	20-11		ccurred at the time, d					
ı	T wil		29b. Signature and title of certifier	ul			29c. Licens	30641	2	9d. Date signe Tu no	2 8°	2005		
	/		30. Name and address of person wh		use of death (Iter	n 23a) (Type,	Print) Be	ack Ru	ver Neck	Road	Balt	2005 More Heufi 2121		
	Sta	ate	31. Date filed (Month, Day, Year)	P .	Registrar's Signa	ature	<i>M</i> 0	/ /				2121		
	Regist		JUN 14 2	005 86	we to	1900								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** P^{M} June 9 2005 2:01 Jose Luis Romero /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 26,1931 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 12XM 2□F Months Days Hours Yrs. Director El Salvador 74 220-06-1007 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County nent of 18 or 18 marked other than "natural", or Itama 23a or 28a-f show my or other traumatic evant, the Medical Evant writtent to notified at 1 ☐ Yes 2X No Completed by Funeral Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9219 Broadwater Drive 20879 USA Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 15XYes 2□No Specify: 153 Salvadoran Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be Amelia S. Velasquez Romero Vicente ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife Health Margarita Esperanza Romero 9219 Broadwater Drive, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages.
Department of It
Important: If Its
any Injury or of June 12, 2005 1 ☐ Burial 2 XCremation 3 ☐ Removal from State A □ Donation 5 □ Other (Specify) Alexandria, Virginia Crematory 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 RAC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Frysician Spiralor disease or condition resulting in death) /Medical Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a nce of) Box 68760, the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year for Dav 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy performed? 2□ No 1**Z** Yes 2 No Division of Vital the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) Manner of eath 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Natural 2 Accident 5 Pending investigation death. 2 No 1 Tyes Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) atter 4 \ Homicide within 24 hours Certifying Physician: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Elsayyad, M.D., 13219 Executive Park Terrace, Germantown, MD 20874 31. Date filed (Month, Day, Year) State JUN 14 2005 Registrar

		-	State Amend Item 5 per Registrar	ate of Ma r fh G82	ryland 15 7-	/ Depa 13-05	artment of l	Health a	and Menta	Hygiei	ne No O O C	01071		
	o. Dhuaisi		Decedent's Name (First, Middle, Last)							of Death	2005 Year	3. Time of Death		
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			Shady Grove Advents 5. Social Security Number 6. Sex		ital (In yrs. las	t hirthday)	Rockvi		24 Hrs. R Date	of Birth	Montgo			
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	28a-f	Director	10e. Street and Number		OTHE	- y 	10f. Zip Code			10a	Citizen of What (
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36	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or Itams 23a or 28a-1 show of other than "natural", or Itams 23a or 28a-1 show svent, the Madical Examilian of the Madical Examilian of the Madical Examilian of the Madical Examilian of the Madical Examilian of the Madical Examilian of the Madical Exami	by Fu	1 Never Married 2 Married	Armed Forces? □ Yes 2 ☐ No f Yes, Give Year or Dates:	0		lf Yes, specify Cub 1 ☐ Yes 2 ☐ No		i, Pueno Rican, e	nc.)	Black, Wh			
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Z	2 should be to and Mental I is marked or reumatic sve	2	Albert James Habich 19a. Informant's Name/Relationship (Type, I	Print)		19b. Mailir	ng Address (Street		stance J			Zin Code)		
	nd 2 state are trau		Leslie Reed - Daught	•			Custis I							
Je,	tem Item		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of natory or other pla	ice)	Date	20c	. Location - City o	or Town, State		
Ē	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marka any injury oc other traumatic once.		1 ☐ Surial 2 ☐ Cremation 3 ☐ Remo	val from State			lemorial		6/11/200)5 0:	lney ,	MD		
Baltimore,			21. Signature of Funeral Service Licensee	4			2. Name and Addre				di Funer			
Ш	207 2 2		Muslim Willed 11800 New Hampshire Ave; Silver Spring MD 2											
Ш	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cause (Final) C											
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier t Certifying Physicis (Check only one) 2 Medical Examiner:	in: To the best o On the basis of and manner stat	examinatio	edge, deat n and/or in	h occurred at the ti vestigation, in my	ime, date an opinion, dea	d place, and due th occurred at the	to the cause time, date	e(s) and manner and place, and di	as stated. ue to the cause(s)		
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	2		> Alicia J. A	listry	1	MD	125	5973	8	J	une 3,	2005		
			30. Name and address of person who compl			23a) (Type,				P. L.	110 .	10 20850		
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amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2005 Year 7, **Physician** June Arthur Martin Scott 12:26p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3970 Scott Tyler Place Indian Head Charles If Under 1 Year If Under 24 Hrs. B. Date of Birth (Months Days Hours Min. Aug. 28, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Yrs. 212-14-8467 83 Director Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3970 Scott Tyler Place 20640 Items 23a U.S.A. Completed by Funeral should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. TYes 2 ☐ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🎇 No Specify: White Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced netural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental H Be Μ. Arthur Scott Mary I. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20640 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Christine Scott 3970 Scott Tyler Place, Indian Head, Wife item 27 i other 1 20b. Place of Disposition (Name of cometery, crematory or other place) June 10,2005 20a. Method of Disposition 20c. Location - City or Town, State to = 1 Burial 2 □ Cremation 3 □ Removal from State ŏ permit. Page Department of Importent: If eny injury or once. Trinity Memorial Gardens `4 Donation 5 Dother (Specify) Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, 21. Signature of Funeral Service Licensee 20640 M00668 4270 Hawthorne Rd., Indian Head. Md. 23a. Part1. Enter the disease, shock, or heart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician Due to (as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SiMslon of Vital Records, þ 1 Yes No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes Hospitel or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA ၉ 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Natural 5 Pending investigation 2 Accident Director 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) 102

State Registrar 51

gistrar's Signature

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31. Date filed (Month, Day, Year)
JUN 1 0 2005

			1 - For State Registrar AMEND #8per IN	State of M 6/15/05,BM		-	artment rtificate			and Me	ental Hy	giene	2000	01070
			Decedent's Name (First, Middle, Las								2. Date of Oe	ath	-440	3. Time of Death
	Physici /Medio		SPURGEON SWI	INSON							June	08	2005	9:42 P M
	Examin		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City, T	own, or	Location o	f Death		4c. (County of Deat	h
			2708 Deer Ridge	Drive					Spri				Montgor	nery
	Funeral		5. Social Security Number 6. S	ex 7. A ⊠M 2 ☐ F	Age (In yrs. Ia:	st birthday) Yrs.	If Under 1	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	16 ear)	9. Birtl	hplace (State or Foreign untry)
	Director		253.26.7430 Usual Residence of Decedent		87		l				Dec. 1	19	17 Whee	eler Co, GA
	land w		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
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	r 288	Director	10e. Street and Number				10f. Zip (10g. Citiz	en of What Co	untry?
	h with	a D	2708 Deer Ridge	Drive			20	904				U.:	S.A.	
	фпа	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S	. 13.	Was Decede	ent of His	spanic Orig	gin? (Spec	cify Yes or No Rican, etc.))- 1	4. Race - Ame Black, White	
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	1 and 2 Heelth a tem 27 is other tra		June L. Swinson/V	Vife		2708	Deer	Rid	ge Dr	ive,	Silve	r Spr	ing, M	20904
ore,	of He of He roth		20a. Method of Disposition	D	l cor	ce of Dispo	sition (Nam	e of			ate		ation - City or	
E	Pages nent of I		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		(8)				.	6/13	/2005	Crown	sville	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itema 23s or 28s-1 ehow amply no other traumatic event, the Medical Examination and ance.		21. Signature of Funeral Service Licen	nsee	+ -	22 H	2. Name and	Addres	s of Facility	TIMER	AL HOM	F TN	r	
<u> </u>	89 5 2		Maney A.	Vacen	- he	11	1800 N	lew l	Hamps	hire	Ave,	Silve	r Sprin	ng. MD 20904
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Σ	after Dire	Certification:	4 Homicide determined	building,	etc. (Specify)	iro, rarri, sti	reor, ractory,	ottioo			City or To	wn, State)	772111007 07 772	nut riouto rattiger,
	splte		29a. Certifier 17 Certifying Ph	ysician: To the be	st of my know	rledge, deat	h occurred a	at the tim	e, date an	d place, a	nd due to the	cause(s) a	and manner as	stated.
	e Ho Fu letely	edicai	(Check only 2 Medical Examone)	niner: On the basis and manner	of examination	on and/or in	vestigation,	in my op	oinion, deat	th occurre	d at the time,	date and	place, and due	to the cause(s)
	To the Hospitel or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	V			29c.	License	number			29d. Date	signed (Month	n, Day, Year)
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	,		30. Name and address of person who					,, .	100					
			Ralph Boccia,					, #4	1100,	веth	esda,	MD 2	20851	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 14 21	005	strar's Signatu	A PO	ede							

		-	For State Registrar		Sta	ate of M	arylan	-	artmer <i>rtifica</i> i				lental Hy	giene Reg. No.		6.		
	Physicia	ın	1. Decedent's Name		s, Last)	TTI							2. Date of De Month June	Day	, 200	rear)5	3. Time o	7 1 1
	/Medic Examin		4a. Facility Name (/	If not institution	, give street	and number))		4b. City	Town, or	r Location	of Death			County of		12130	
	LAUIIIII		Casey Ho	use						kvi1					lont g			
	Funeral		5. Social Security N		6. Sex 1 ☐ M 2			last birthday, Yrs.	If Unde Months	r 1 Year Days	If Unde Hours	Min.	8. Date of Bi (Month, Di July 2	rth ay, Year)	20 1	Cour	place (State	or Foreign
	Director	-	214-36-1 Usual Residence o			TX .	66	115.					July 2	2,19	36 V	rrg	inia	
	land	ŀ	10a, State	10b. County			10c. Cit	y, Town or L	ocation							1	10d. Inside (City Limits
	Mary 1 sh	ţ	Md.	Montgo	omery		Gai	ithers	burg								1 TYes	s 2X No
	r 28a	Irec	10e. Street and Nu	mber					10f. Zi	p Code				10g. Cit	izen of Wh	nat Cour	ntry?	
F	th with	alD	8 Goodpo	rt Cou	ct						208				ited	Stat	ces	
5 ACCHETT 215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Medical Ever it are navel be rediffed at	by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	4.7	ied 1	as Decedent med Forces ☐ Yes 2 ☐ Yes, Give ear or Dates:	? No	.S. 13.	Was Dece If Yes, spo 1 Tes		lispanic C an, Mexic Specif		ecify Yes or N Rican, etc.)	0-		, White,	_	
45	d within 72 ho jiene. r than "natur ing Medical	Completed	(Spe	15. Deceden	t's Education	pleted)		16a. Dece (Giv	dent's Usi kind of w	al Occup	ation during mo	st of work	ing	16b. K	ind of Bus	iness/In	dustry	
2 S	Atthin ne.	du	Elementary/Seco			ollege (1-4or	5+)		<i>bo Not</i> maker		d)			Own	n Hom	P		
2			12 17. Father's Name	/First. Middle.	Last)			Home	illa KCI		18. Mot	her's Nam	e (First, Middle					
2	d ta b	Be c	James Do								E1.	aine	Bise					
<u> </u>	2 should and Mer is marke sumatic	٩	19a. Informant's N	lame/Relations	hip (Type, P.	rint)		19b. Mail	ing Addres	s (Street	and Num	ber or Rur	al Route Numb	ber, City	or Town, S	tate, Zip	Code)	
35 ₹	and 2 : Balth ar n 27 is		Richard	H. Saco	chetti	(Husb	and)	8 G	oodpo	rt C	ourt	Gait	hersbu	rg, N	1d. 2	0878	3	
Baltimore,	Pages 1 nent of H unt: If iter		20a. Method of Dis 1 Burial 2 4 Donation	Cremation		al from State	9 0	Place of Disponentery, cre tropo	matory or	other plac		June 200.			ocation - C xandr	•	own, State	
Balti	permit. Pag Department Important: I any Injury o once.		21. Signature of F	uneral Service	Licensee	laur			2. Name a .0 Ea:			De	Vol Fun Dr. Gai				d. 20	877
			23a, Part1, Enter	the disease, or art failure. List	complication	ns the cause	ed the deat	th. Do not er	iter the mo	de of dyir	ng, such a	as cardiac	or respiratory	arrest,			Approxima Interval Be	etween
	Physician /Medical		Immediate Cause disease or conditi resulting in death)	(Final			tic A		rcin	oma I	Prima	ry U	nknown				Onset and	1 Death
	Examiner	er.	Sequentially list or	onditions,	b	Due to (or a	s a conseq	quence of):							<u>.</u>			
	cuted nd ransit	Examiner	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated event	LS	S													
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death)	Last	L _{d.}	Due to (or a	s a conseq	quence of):										
9	ifficate g phy as the	ledic																
O. Box	The law requires that the death certifics to has been signed by the attending phoage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months? ☑No	1 4	yes, outcom Live birth Pregnant Unknown	2 ☐ Feta at time of d	al death 3	□Ectopic □ Other (s		у				23d. Date Mont		Pery Day	Year
ds, P.O.	signed by	þ	Part II. Other sign	ificant conditi	ons contribu	ting to death	but not res	sulting in the	underlying	cause giv	ven in Par	t I.					the cause of	
Š	w require been si should I	letec						-					24a. Wa	s an	24b. W	ere auto	opsy finding	s available
Division of Vital Records,	The law ite has	Completed											auto	opsy formed?	pr de	ior to co	ompletion of 2□ No	cause of
ta	ian: rtifica	BeC	25. Was case refe examiner?	erred to medica	al						26. Pla	ce of Dea	th (Check only	оле)				
> 7	hysic his ce I direc	To		No	Hospi	1 🗆 Inpa		ER/Outpati		JOA		Nursing H	ome 5 Res				h)Hosp	ice
0	ng Pl		27. Manner of Dea 1 X Natural	5 Pendi	ng	Ba. Date of In (Month, D	ijury Day Year)	28b. Time Injury		28c. Inju Wo		DN-	28d. Describe	how inju	iry occurre	d		
Sio	Attending ir death. ector: Afte by the fune	catl	2 Accident	invest 6 □ Could	igation not be	DI	-i A a fa		M		Yes 2	□N0	28f. Location	/Street a	nd Numbe	r or Bur	ral Boute Mi	umber
Divi	al or At s after of al Direct ad in by	Certification:	4 Homicide	data		Be. Place of I building,	etc. <i>(Speci</i>	ify)	treet, rack	ory, office				own, State				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one)	1 Certifyi 2 Medica	Examiner:	n: To the bes On the basis and manner:	of examina	owledge, dea ation and/or	ath occurre investigation	d at the ti	me, date opinion, d	and place, leath occur	, and due to the rred at the time	e cause(s e, date an	s) and man id place, ar	ner as s nd due t	stated. to the cause	∌(s)
	within comp	Ž	29b. Signature an	d tile of eartific	AL			_	2	9c. Licen:	se numbe	21	8	29d. Da	ate signed	(Month,	Day, Year)	-
			30. Name and add							ederi	ck A	ve. (Gaither	sbur	g, Md	. 20	3877	
	Sta	ate	31. Date filed (Mo	onth, Day, Year	-1	22 Pagis	trade Sign	aturo										
	Regist		J	UN 14	2005	Born	0 1	190	We									

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryla nd	-	artment <i>tificate</i>			d Mer		ene	0.0	01000
	Physici	an	Decedent's Name (First, Middle, L SIDNEY				CDIN	DEI			Date of Death Month	Day	Year	3. Time of Death
>	/Medic	al	4a. Facility Name (If not institution, gr	S.	r)		SPINI 4b. City, To		Location of De		UNE	9 2 4c. County	005 of Death	11:30A ^M
ı		Ŭ.	HEBREW HO	ME					VILLE			MON	TGOME	ERY
	Funeral Director		086-05-3744	Sex 7. A 1 ☑ M 2 □ F	Age (In yrs. la:	st birthday) Yrs.	If Under 1 Months	Year Days	Hours M	in. M	Date of Birth (Month, Day,) IAY 16,	1918	9. Birthp Cour NEW	place (State or Foreign NORK
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation			<u>-</u>			1	0d. Inside City Limits
	a-fsh	ctor	MD MONTGO	MERY			ROCI	KVIL	LE					1 ☐ Yes 2 No
	death with the Maryland rms 23e or 28e-f show froust be nutified at	Director	10e. Street and Number	DT 4 077			10f. Zip C				100	g. Citizen of \		ntry?
	ms 23	Funeral	705 FLETCHER 11. Marital Status	12. Was Deceder		. 13. V	Vas Decede		20851	(Specify	Yes or No-	USA 14. Rac	e - Americ	an Indian,
30	J within 72 hours after death with tha Marylan jiene. r than "naturel", or Items 23a or 28a-f show Ite Modest Exar instrems be nullited at	by Fur	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	ĮΝο	1	Yes, specif	_	panic Origin? , Mexican, Pu Specify:	ièrto Rica	an, etc.)		ck, White,	
5	2 hour		15. Decedent's 8	Year or Dates Education			lent's Usual				16	Sb. Kind of B		
2	filed within 72 Hygiene. hthar then "nal	Completed	(Specify only highest g.	College (1-40) 5+	r 5+)	life. L	OO NOT use	retired)		working		JNIVER		
ב	Hys H	e Cor	17. Father's Name (First, Middle, Las			MA'L	HEMAT:			Name (Fi	irst, Middle, Ma	JS GOV		NT
Maryland 21215-0036	a = 0 \$	To Be	JACOB	~	SPIN	NDEL			ESTH		, , , , , , , , , , , , , , , , , , , ,		SENBL	ATT
Mar	2 sa ar is		19a. Informant's Name/Relationship TERESA SPINDEL				g Address (: LETCHI				oute Number, (<i>State, Zip</i> 0851	Code)
_	t Health item 27	3	20a. Method of Disposition			ce of Dispo	sition (Name	of	1	Date	VILLE,	oc. Location -		wn, State
Ē	Pages nent of l ant: If its		1 XBurial 2 ☐ Cremation 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		9	-	natory`or oth MEM。			12-20	005 R	OCKVIL	LE, N	MARYLAND
Baltimore,	parmit. Departr Importa any inju		21. Signature of Futeral Service Lice	ense	ICE	≨ ∆ 22	. Name and	Address	of Facility	NERA	_			G, MD 20904
8/60,	Physician for a second of the	dical Examiner	shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Chease of highly that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c.		ence of):	near t	عان عان المان	(· · ·) ·					Interval Between Onset and Death
.C. Box 6		Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d	death 3	Ectopic pred Other (spec					23d. Dai	te of delive	ory Day Year
ds, F	s tha	by	Part II. Other significant conditions		but not result	ting in the ur	nderlying cau	ise give	n in Part I.					e cause of death?
Vital Record	The ate h	e Completed	25. Was case referred to medical									ed?	Were autoporior to condeath?	psy findings available inpletion of cause of 2 No
DIVISION OF VI	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	To B	examiner? 1 Yes 2 No 27. Manuer of Death 1 Natural 5 Pending 2 Accident investigative	Hospital: 1 ☐ Inpa 28a. Date of In (Month, D		P/Outpatien 28b. Time of Injury		Other	4 Nursing	g Home	heck onlone 5 Resident Describe how	ce 6 □Oth		′)
DIVIS	el or Atter s after dea il Director od in by the	Certification:	3 Suicide 6 Could not determine	d 286. Place of I	njury - At hom etc. <i>(Specify)</i>	ne, farm, stre	eet, factory, o	office			Location (Stre City or Town,		er or Rura	l Route Number,
	he Hospit n 24 hour na Funere	edical	29a. Certifying P (Chock only 2 Medical Exa	hysician: To the besiminer: On the basis and manner:	of examination	ledge, death on and/or inv	occurred at restigation, in	the time	e, date and pla nion, death oc	ace, and ccurred a	due to the cau at the time, date	se(s) and ma e and place,	anner as st and due to	ated. the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier					License	_			I. Date signe		,
	20		/ tay 3 W/	le .	>		IV.	3 6 3				in 9,	200	1
			30. Name and ad ress of person who	completed cause of	death (Item 2	Recd	Print) Bock	cille	Mei;	(or d	108	5-2		
:	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 0 200	completed cause of G(2(mg) 22. Regis	trar's Signatu	Ire Jase	2		}					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Paul J. Spadacino June 2005 9:52A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months 578-34-8831 Director 75 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23s or 28s-1 ehow any injury or other traumatic event. Its Medical Examinar must be notified at once. 10d. Inside City Limits MD Worcester Ocean City Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 136th St., Villa B 21842 US 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Vice Pres. of Funds Mngmt. Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Spadacino Carrie Cilento 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodora Ann Spadacino (Wife) 407 136th St., Villa B, Ocean City, Md. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 6-10-05 Silver Spring, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Francis Arescollins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laydre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Mins disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** wroses Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner signed by the attending physicien and id be detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No al or Attanding Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Certification: Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М filled in by the 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Budd IV) 85 31. Date filed (Month, Day, Year)

JUN 13 2005 State Registrar

			1 - For State Registrar	State of Marylar			of Health and of Death		ene g. No. 2 () (15 2	1077
	Q s		1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month			ne of Death
	Physici /Medic		Joseph John S	ielski				June 9,	-	Year 3:1	м ф о.
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of Dea	ath	4c. County o		
			Villa Rosa Home			Mit	chellvill	е	Princ	e Georg	e's
	Funeral		5. Social Security Number 6. Sec	TM 20E	* *	If Under 1 Y Months Da	ear If Under 24 Ha ays Hours Mi			9. Birthplace (Sta	
	Director		033-54-9290	9:	L Yrs.			Feb. 18,	1914	New Jer	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or Lo	cation				10d Insid	de City Limits
	danyl f sho	ō								1	Yes 2X No
	28e-	ect	10e. Street and Number	tgomery	Bro	ookevil		10	g. Citizen of Wh	nat Country?	
	Mith Sa or	<u></u>	19101 Georgia Ave	enue			0833	10	_	ISA	
	72 hours after death with the Maryland netural; or tlams 23a or 28e-f show Jical Exa. iliner out be neilliad at	Funeral Director		12. Was Decedent Ever in U	J.S. 13.			Specify Yes or No-		- American India	n.
ယ	r Itar		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 3 No	(of Hispanic Origin? Cuban, Mexican, Pue	irto Rican, etc.)		White, etc.	
ဇ္တ	al', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□ Yes Ž□	No Specify:		Specify:	White	
Maryland 21215-0036	"netural", or	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Oc	ccupation one during most of w	orkina 1	6b. Kind of Busi	iness/Industry	
2	e * 3	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	atired)	Orking			
2	70 75 75 75	S		5+	Pr:	iest			eligiou		
<u>n</u>		Be	17. Father's Name (First, Middle, Last) Unknown					ame (First, Middle, M	aiden Sumame,)	
yla	should be nd Mental marked o	^c				-	Unkn				
Jar	and rand		19a. Informant's Name/Relationship (Ty Mark Garrow/ Super					Rural Route Number,			
e, l	1 and Health					sition (Name o		NE, Washin			
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If itam 27 is marked any injury genther traumetic e ance.		20a. Mathod of Disposition 1 Burial 2 Cremation 3 R	Removal from State	cemetery, crer	natory`or other	place)	June 14	Jc. Location - C	ity or Town, State	8
ŧΞ	t. Partmer		'4 □Donation 5 □ Other (Specify)				rian Father	2003		idge, MA	1
Bal	Deparement of the popular in procession of the p		21. Signature of Funeral Service Licens	0	F1	Name and Ac	dress of Facility Collins	Funeral	Home_In	c	
			230 Borth Potor the disease or compli	Jooking				vd, W, Sil		-	20901
н			23a. Part1. Inter the disease, or complishock, or heart failure. List only or	ne cause on each line.	tri. Do not ent	er trie mode oi	dying, such as cardi	ac or respiratory arres	it,		Between and Death
	Pnysician /Medical	ě Y	Immediate Cause (Final disease or condition resulting in death)	Metastatic		oma				Year	cs
ja,	Examiner) II		Due to (or as a consec	quence of):						
	Mark I	ē	if any, leading to immediate	Due to (or as a consec	quence of):						
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or Irijury) that initiated events								
Ć	exec in an ial-tr	Exa	resulting in death) Last	Due to (or as a consec	quence of):						
8760,	rate be executed hysician and the burial-transit	icai		d							
Ø	tificat g ph) as th	ed	-								
Вох	death certific e attending pl d tor use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn 1□Live birth 2□Feta		Transia a a a a a a a a a a a a a a a a a a			23d. Date	of delivery	
	deat e atte	icia	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4☐Pregnant at time of c]Ectopic pregna] Other (s <i>pecif</i>)			Month	n Day	Year
P.0	at the de by the stached	hys	9 Unknown	9□ Unknown							
	requires that the een signed by th nould be detache	by F	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying cause	given in Part I.	23e. Did toba	cco use contrib	ute to the cause	of death?
ord	w require been si should i							1 🗌 Yes	2 □ No 3	Probably	(XUnknown
၁၁	aw as b 2 sl	ompieted						24a. Was an autopsy	24b. We	ere autopsy findir	ngs available
Vital Records,	The ate h page	Com						perform	ed? dea	ath? Yes 2 No	01 04436 01
ita	sicien: Th certiticate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one			
of V	S S	To	1 Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA	Other: X Nursing	Home 5 ☐ Residen	ce 6 Other	(Specify)	
0 0	ding Ph th. After th tuneral		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. I	njury at Work?	28d. Describe how			
0	Attanding r death. Betor: After by the tune	ati	2 Accident investigation				1 ☐ Yes 2 ☐ No				
Division	or Attan after deat Director: in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str	eet, factory, off	ice	28f. Location (Stre City or Town,	et and Number State)	or Rural Route A	Vumber,
	itel or ris af ral D							1			
	To tha Hospitel within 24 hours a To the Funeral Completely tilled in	dicai	(Check only 2 Medicel Examin	sician: To the best of my kno ner: On the basis of examina	owledge, death	occurred at th	e time, date and plac ny opinion, death occ	e, and due to the cau	se(s) and mann and place, and	er as stated, d due to the caus	se(s)
	To tha within 2. To the complet	Med	onej	and manner stated.							
	To To	~	29b. Signature and title of certifier			29C. LIC	D25079	290	June 10	Month, Day, Yea	
,			P CUELLE.				D23013		Julie 10	2005	
			30. Name and address of person who co John Yablonowitz,	,				WB 0075			
	_0						e, Lanham	, MD 20706			
100	Sta	ie .	31. Date filed (Month, Pay, Year) 3 20	32. Abgistrar's Signa	H A	24/2)					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Req. No. (1) Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Francisco Boongaling Sawali June 9, 9:00pM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 25, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 № M 2 🗆 F 81 214-25-9287 Philippines Director 1924 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Marvland Silver Spring Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3830 Wendy Lane 20906 Philippines Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Never Married 2 Married ☐Yes 2 No Specify: White ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: f Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced "naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming and Mental Hygie Is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any injury or gither traumetic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Catalino Sawali Venancia Boongaling 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3830 Wendy Lane, Silver Spring, MD 20906 Penny Sharma/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Nat'l Cemetery of Baco 6-16-05 Baco, Philippines 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francias Address Fineral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician Cerebral Infarction disease or condition resulting in death) Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease Filips) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner O. Box 68760, burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown ورنه Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Becords, by Ok (201) þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2X No of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred - FANT SAMALL B Hospitel or Attending Pl Certification: 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 100 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 06-10-2005 D5434 use of death (Item 23a) (Type, Print) 30. Name and address of person who Neeraj Chopra, M.D. P.O. Box 83819, Gaithersburg, MD 20883

State Registrar 31. Date filed (Month, Day, Year)

RANCISIO

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** Florence B. Semmia June 1:00 p 6, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1328 Swan Drive Annapolis Anne Arundel Date of Birth (Month, Day, Year) Oct. 16,1923 If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 81 1 ☐ M 2 🔀 F Yrs NY Director 578-28-0573 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-1 show Examiner must be notified at Annapolis Anne Arundel 1 ☐ Yes 2X No MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 USA 21401 1328 Swan Drive Items 23e Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No White Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: Specify Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 and Mental Hygiene. Is marked other than College (1-4or 5+) Railroad Administration Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maxine Mabie Mario Otero ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2803 Lakeview Drive, Annapolis, MD Pamela Ann Parker/Daughter Department of Health a Importent: If item 27 is any injury or other tra 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition June 11, Glenwood Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State Washington, DC ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Buneral S Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 minutes Acute Myocardial Infarction Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 5 minutes Coronary Thrombosis Sequentially list conditions.
If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Coronary Atherosclerosis Uncertain and Due to (or as a consequence of): Several Box 68760. attending physician Diabetes Mellitus Physician/Medical Years IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 XNo Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown page 2 should Completed Hypertension 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 X No director. Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 5 Pending investigation 1 Yes 2 No after death. 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours a Tactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0009215 June 8, 2005 zurenco arcus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lawrence D. Marcus, M.D. 10313 Georgia Ave, Silver Spring, MD

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. R

istrar's Signature

		For State Registrar	State of Mar	•	Certificate of D		, ,	giene Reg. No⊋ () () () ()	* 0
		Decedent's Name (First, Middle	, Last)				2. Date of Dea		3. Time of Death
Physici		Edward Eugene	Snyder				Zune	Day Ye	
/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of D	
		North Aras	idel Hasp	tal	Glen B	urnie		Anne	Annadel
Funeral Director		5. Social Security Number 236–20–4035	6. Sex 7. Age (1 1 X M 2 ☐ F	In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar. 2	h 9.	Birthplace (State or Foreign Country) WV
_		Usual Residence of Decedent					riat. Z.	7, 1920	VVV
yland		10a. State 10b. County		0c. City, Town o		Dowle			10d. Inside City Limits
a-f s	ctor	MD Anne	e Arundel		Severna	i Park			1 ☐ Yes 2 XNo
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examitizations to be rediffed at once.	Funeral Director	10e. Street and Number 564 Knollwood R	Road		10f. Zip Code 21	146		10g. Citizen of What	Country? SA
r dea	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp. Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian, /hite, etc.
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permit. Depa tm Importa any inju		21. Signature of Euneral Service L	ice spe		22 Name and Address	of Facility		arna Park	Funeral Home
89 = 8		Alaoner K	144		495 Gov. F	itchie F	Wy, Seve	erna Park	, MD 21146
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death certificate attending physi	fedi	15551115							
th ce tendii r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2					23d. Date of Month	
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ie dea the at: hed fo	/Si	1 ☐ Yes 2 ☐ No	4□Pregnant at tim 9□Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				•
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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

JUN 0 9 2005

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

29c. License number
29d. Date signed (Month, Day, Year)
29d. Date signed (Month, Day, Year)
3005

Print)
Hospital Dr Glen Bruc MD 20061

Joshua Shalaby 05-04101 RPD

)			1 - For State Registrar	State of	Maryland /	-	artment <i>rtificate</i>				-	giene Reg. No. 2	005	5 21081
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	Examir	ier	4a. Facility Name (If not instituti		iber)		4b. City, T						unty of Dea	
	Funeral		25615 Ischer I 5. Social Security Number	6. Sex	7. Age (In yrs. last i	birthday)	If Under 1	Year	burg If Under	24 Hrs.	8. Date of Bir	th Car	roline 9. Bir	tholace (State or Foreign
	Director		217-23-6418	1 🛣 M 2 🗆 F	16	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Feb. 10	, 1989	C	ountry) Cyland
	and **		Usual Residence of Decedent 10a. State 10b. Count	lv	10c. City, To	wn or Lo	ocation					-		10d. Inside City Limits
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and	tal H ad oth	Be	17. Father's Name (First, Middle John Steven]								(First, Middle,		,	
Maryland 21215-0036	2 should be filed within 72 hours after dea and Mental Hygiene. is marked other than "natural, or flame raumatic evant, Ir e Medical Examination.	P	19a. Informant's Name/Relation		10	h Mailir	Address (Dawn Route Number			Zin Codel
	ges 1 and 2 should be filed within 72 hours after death with tha Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or itema 23a or 28a-f ahow or other traumatic event, If a Medical Examinar mat be notified at		Deborah Adam											21632
Je,	ts 1 and the street of Heart itam		20a. Method of Disposition		20b. Place	of Dispo	sition (Name	of		Da				Town, State
Ë	Page nent c ant: If ury or		1 X Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (statte !	L Cr	est (Cem	. 0	6/18	/05	Feder	alsb	ourg, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trae		21. Signature of Funeral Service	t. Ester		22	2. Name and	Address	s of Facility ain	y Fra St.,	mptom Fede	Fune ralst	eral ourg,	Home, P.A. MD 21632
			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that ca st only one cause on ea	used the death. Do	o not ent	er the mode	of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
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9	ertifica ding pl	Med	IF FEMALE:	00- 16										
Вох	~ ~ ~	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live bir	come of pregnancy rth 2 Tetal dea ant at time of death		Ectopic preg					23d.	Date of del Month	livery Day Year
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<u>ر</u>	requires that the een signed by th nould be detache	by Pł	Part II. Other significant condit	tions contributing to de	ath but not resulting	in the u	nderlying cau	se giver	n in Part I.		23e. Did to	obacco use o	ontribute to	the cause of death?
Vital Records,	w require been sig should b	ed t									101	res 2 N	o 3□Pr	robably 4 Unknown
ecc	aw as b 2 sl	Completed									24a. Was		b. Were au	utopsy findings available completion of cause of
E.	Tha cate ha	Con									, perto	rmed? 2 \(\text{No} \)	death?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:							Check only o			
of	Phys	- T	1 Yes 2 No 27. Manner of Death	1 1 1 1		Outpatien . Time of	t 3 DOA		4 🗆 1401		e 5 🗌 Resid			city) at scene
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N S	al or Attendii after death. I Diractor: A d in by the fu	ifica	3 Suicide 6 □ Could	mined 286. Place	of Injury - At home,	-		office			If Location /	Street and No	imber or Ri	ural Route Number
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	To the Hospital or Atlanding Physician: Tha within 24 hours after death. To tha Funaral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the t il Examiner: On the ba- and mann	sis of examination a	ge, death and/or inv	occurred at vestigation, in	the time my opi	e, date and inion, deat	d place, an h occurred	d due to the	cause(s) and	manner as ce, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of pertific	ier	1.1		29c. I	icense OCI	number /NF			29d. Date sig	ned (Monti	h, Day, Year)
				WI. J	t							June	16, 2	005
			30. Name and address of perso	n who completed cause	of death (Item 23a) (Type,	Print 111	Penr	n Str	eet	Baltin	nore, I	Maryla	and 21201
	Sta	te	31. Date filed (Month, Day, Yea		gistrar's Signature	-								
	Registr	ar	JUN 2 0 2	005	w the p	Jacon .	M. P							

Jeremy Shalaby 05-04102 RPD

72 hours after

Maryland 21215-0036

Baltimore,

certificate be executed

Box 68760

P.0.

Division of Vital Records,

ō

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Shalaby Jeremy Kenneth June 15 2005 1620 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Federalsburg 25615 Ischer Road Caroline 8. Date of Birth (Month, Day, Nov. 29 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days 1 X M 2 ☐ F 14 Yrs. 1990 Delaware 213-31-3257 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **ehow** r than "natural", or items 23s or 28s-f shove the Medical Examinar must be notified at MD Caroline Federalsburg 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21632 4076 Pepper Road United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: White 1 ☐ Yes 2 A No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filled within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fl and Mental H is marked of Shalaby Deborah Dawn Adams Kenneth Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health & ant: if item 27 is 4076 Pepper Road, Federalsburg, MD 21632 Mother other 1 Deborah Adams/ Oa. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State ō permit. Page Depertment of important: if any injury or once. Hill Crest Cem. 06/18/05 Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Michael askur Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple INJUNE Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a nonsequence of) Examiner attending physician and for use as the burial-translt Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1¥Yes 2□ No 1XYes 2□No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4\square \text{ Nursing Home}}$ 5 \square Residence 6 $\cancel{\text{M}}$ Other (Specify) at scene 70 1√2 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 5 ☐ Pending investigation 1 Natural 4:06 PM 1 ☐ Yes 2 📉 No 15/05 passenger at ATV involved in collision 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2561 ScHer Rund 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Ischer Rund outside street tederals Burs MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caus (s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and matrix of stated. 29a. Certifier Medical within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number OCME June 16, 2005

State Registrar

JACK 31. Date filed (Month, Day, Year)

30. Name and address of perso

M.D. 32. Registrar's Signature

JUN 2 0 2005

ORIGINAL

who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Stinson JUNE 2005 2 A Nora /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Manor Frederick Northampton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 4, Birthplace (State or Foreign Country) **Funeral** 1□M 2/DF 94 417-10-7031 abama Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, If a Medical Exament must be notitled at 10a State 10b. County 1 Yes 2 No Gaithersburg Md. Mont Directo 10e. Street and Number 10g. Citizen of What Country? 24314 HIPS/CY U. S. A. 20882 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home maker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Calvin Flowers Clowers William VICKIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24314 Hip Sley Mill Road Gaithersburg Md. 20882.

20b. Place of Disposition (Name of Date 20c. Location - Div or Town, State Stinson McKee 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ō = 0 permit. Pege Department of Important: If sny injury or once. Smithsburg June 10. avem. 21. Signature of Funeral Service Licensee 22 Aame and Address of Facility LOUNS FUNDACHOME GARY LE TRED LEVER MO They X. Sount ST 10 23a. Part 1. Enter the cisease, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in thilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALZHOMERS DISTASE VEGES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to min ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physicien and as the burial-transit Due to (or as a consequence of): attending physicien I for use as the buria Division of Vital Records, P.O. Box 68760 Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Dav 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 X No 1 🗌 Yes 3 Probably 4 Unknown HEPORTON SION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CONGOSTIVE YONRE EALLURE page 2 s autopsy 1 ☐ Yes 2 ☐ No certificate 2 PNo To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 Tyes 2 □ No M 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 172171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21793 Bo WACKERSVILLE RICHARD GOUGH 13000 JUN 1 3 32. R strar's Signature State 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** Ezra Toms Shafer 2005 /Medical June .20P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital 7. Age (În yrs. last birthday) Frederick Under 1 Year | If Under 24 H Frederick Frederick Memorial 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F Months Days Hours Min Director 85 1920 Maryland 220-18-1536 March 2, Usual Residence of Decedent Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28a-f show treumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Frederick Frederick the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7901 Rocky Springs Road 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hyglene. 7 Is marked other then "r lifed within Elementary/Secondary (0-12) College (1-4or 5+) 12 Laboratory Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lester E. Shafer Abbie Marie Forney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an Mae E. Shafer / Wife 7901 Rocky Springs Road Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Itel
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State June 11, 2005 4 □ Donation 5 □ Other (Specify) Mt. Olivet Cemetery Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of F 1621 Opossumtown Pike Frederick, Maryland 21702 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease or con shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician Leave -ongertive disease or condition resulting in death) /Medical Due to (or as nsequence of) Examiner neemono Sequentially list conditions, if any, leading to immediate cause. Enter Ur Jerryng Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy The law requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ be artu 1 Pres 2 No 3 Probably 4 Unknown Completed Hyper Hense or 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 Chronez destruetre disease 2 No 1 ☐ Yes Hospitel or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending Injury death. investigation 2 🗌 No 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 MD D-54636 June 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed W. Haque, M.D. 700 Montclaire Avenue Frederick, Maryland 21701 31. Date filed (Month, Day, Year) estrar's Signature 32. Re State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year as AM June Margaret Turner 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8100 Conn. Ave. #1416 Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2XF Year Days Hours Min. Yrs Sept. 19,1906 98 South Carolina Director 118-18-5689 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits *show in than "natural", or items 23a or 28a-f show The Medical Examinar must be motified at 1 Yes 2 No Maryland Montgomery Chevy Chase Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8100 Conn. Ave. #1416 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permil. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I be important: If Item 27 is marked other than "natural; or iten any injury of other traumetic event. Ite Medical Exactinat once. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Dargan Anna Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6121 Western Ave., N.W. Washington, DC 20015 Raymond Turner/Son 20b. Place of Disposition (Name of June 8 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alex.,Virginia 22. Name and Address of Facility 222 aciliy DeVol Funeral Home 2222 Wisconsin Ave. N Washington, D.C. 20007 21. Signature of Fineral Sevi Men 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Priysician Breast Tetastatic Month 5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. F 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Comp autopsy performed? certificate 2 🗌 No 2 X No 1 Yes the Hospital or Attanding Physician: nin 24 hours after death. the Funarel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☐Xlo 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funarei Completely filled i 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier K. Eine De 00043427 05 4.0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karl Eric DeJonge, M.D. 216 Michigan Ave., N.W. Wash., D.C. 20017 31. Date filed (Month, Day, Year)

JUN 1 0 2005 A. Registrar's Signature State Registrar

			For State Registrar	State of I	Maryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			iene eg. No. 👝 🦽		
	Physici	an	Decedent's Name (First, Michael Control of the					2. Date of Deat Month	th Day	Year	3. Time of Death
	/Medio		SARLA V(4a. Facility Name (If not institute)	OHRA tion, give street and number	er)	4b, City, Town, or	Location of Death	JUNE	4c. Count	2005	7:50 P M
	Exami		THE NATIONAL 1			ROCKVILI				GOMERY	Y
	Funeral Director		5. Social Security Number 220–86–6683	6. Sex 7. 1 □ M 2 F	Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6/26/19	20°	9. Birthpla Count	ace (State or Foreign ry)
	and *		Usual Residence of Decedent 10a. State 10b. Cour	ntv	10c. City, Town or Lo	ocation					d. Inside City Limits
	Maryli f sho	to	M	GOMERY	ROCKVILLE						1 Yes 2 No
	th the or 28a e notii	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Count	ry?
	ath wi		9701 VIERS DR	1		20850			USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or and traumatic avant, If a Medical Examin of must be notified a one.	by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 ▼ Widowed 4 □ Divorce	If Yes Give	No No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ck, White, e	tc.
200	72 hou natura licul E		15. Deced	ent's Education hest grade completed)	16a. Dece	dent's Usual Occupa	tion		16b. Kind of B		1112
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an	lid be fental rked o	To Be	LAL CHAND MEH				PANNA KAI		naiden Suman	110)	
lary	2 should and Men is marke sumatic	_	19a. Informant's Name/Relatio	nship (Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	I Route Number,	City or Town,	State, Zip (Code)
Z W	Health Health Health			SON	The second secon	BRADLEY B		-			
Baltimore, Maryland	Pages 1		20a. Method of Disposition 1 □ Burial 2 □ rematio 4 □ Donation 5 □ Other	n 3 Removal from Sta (Specify)	NORTHERN	VA. CREMA	TORY 6/14	/05	Oc. Location -	TON, V	7A
Ba	pemit. Dep. rtn Imports any nju		21. Signature of Funeral Service	Ce Licensee Woldling		2. Name and Address O1 N. FAI					
i			23a. Part1. Enter the disease, shock, or heart allure. L	or complications that caus ist only one cause on each	ed the death. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arre		,	Approximate Interval Between
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a pu/	as a consequence of): L As a consequence of):	5m	bolica				Onset and Death
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		ner	Sequentially list conditions, if my Isaang to im 15 cause. Enter Underlying Cause (Disease or injury	b. Due to (or s	is a consequence of):	rilai				1	64157
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
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O. Box	The taw requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat	te of delivery	/ Pay Year
P.0	res that t signed by l be detac	by Ph	Part II. Other significant condi	tions contributing to death	but not resulting in the ur	nderlying cause giver	n in Part I.	23e. Did toba	acco use conti	ribute to the	cause of death?
spi	w require: been sig should b		Diahel	es				1 ☐ Yes	s 2 12 No	3 🗌 Probab	oly 4 Unknown
Records,		Completed	Congest	ise heat	fa.lure			24a. Was an autopsy perform	ed?	Were autops prior to comp death?	sy findings available bletion of cause of
Vital	Physician: The raths certificate hard director, page	Be	25. Was case referred to medic examiner?				26. Place of Death		-		
ō	무 부 Ta	٦.	1 Yes 2 No	Hospital: 1 ☐ Inpa 28a. Date of In		t 3☐ DOA Other 28c. Injury a	4 Nursing Hon	ne 5 Resider			
lon	Attending I r death. ector: After by the funer	ation	1 Natural 5 ☐ Pend		Jay Year) Injury	Work?	es 2 No	.ou. Describe not	w injury occurs	θū	
Division	Pir Dir	Certification:	3 ☐ Suicide 6 ☐ Coul	mined 286. Place of I	njury - At home, farm, streetc. (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	et and Numbe State)	er or Rural f	Route Number,
	To the Hospitat or Ai within 24 hours after of To the Funeral Direc completely filled in by	edical C	29a. Certifier NII Certify (Check only one) Certify	ring Physicien: To the besited Exeminer: On the basis and manner:	or examination and/or inv	occurred at the time restigation, in my opin	e, date and place, a nion, death occurre	nd due to the cau d at the time, dat	use(s) and ma te and place, a	nner as state and due to th	ed. ne cause(s)
	To the within 2 To the complet	Me	29b. Signature and tuto of certif	ier		29c. License	number	29	d. Date signed	(Month, Da	y, Year)
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	1		30. Name and address of perso			•					
	Sta		Sarvell G. Maller, 31. Date filed (Month, Day, Yea		Leisure World I trar's Signature	BIVO.; Silve	er Spring, 1	MD 20906		-	
	Registra	4	JUN 15	32 Regis	J. By	NEW TO					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylaı	nd / Depa <i>Cei</i>	artment rtificate			and M	lental Hy	giene	20	0.5	211	187
I	Physici	an	1. Decedent's Name (First, Middle, Las Charlotte Alene	,							2. Date of De Month June 2	-	 305	Year	3. Time	
	/Medic Examir		4a. Facility Name (If not institution, give		nber)		4b. City, T	Fown, or	Location o	of Death	Julie 2			of Death	2:37	р м
			Sunrise House				Rock		-				Mon	tgom	ery	
	Funeral Director		5. Social Security Number 6. S 181-12-0999	ex □M 2 X □F		. last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi	ay, Year)			place (State ntry)	
	ס		Usual Residence of Decedent		8	3					June 1	1, 19	921	Pen:	nsylva	nia
	anylan show det	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation								10d. Inside (•
	the M	Director	Florida Vol	usia			DeBar			· · · · · ·						s 2 🔀 No
	3a or	ä	93 Goddard Driv	e			10f. Zip (713			10g. Cit	izen of V USA	Vhat Cou	ntry?	
	death	nera	11. Marital Status	12. Was Dece			Nas Decede	ent of Hi	spanic Orio	gin? (Spe	ecify Yes or No	p-	14. Rac	e - Ameri	can Indian,	
36	s after or Ita	by Funeral	1 Never Married 2 Married	1 ∐Yes If Yes, Give	2 ∑ No ∍		fYes, specif 1 □ Yes 2		n, Mexican, Specify:	, Puerto	Hican, etc.)			k, White, White		
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or itams 23a or 28a-f show avent, I're Medical Eracia or medical collinates.		3 ☐ Widowed 4 ☐ Divorced	Year or Da	tes:		ient's Usual					405 16				
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Maryland	m = 0 5	Be	17. Father's Name (First, Middle, Last) Joseph Heidler C	0011017							(First, Middle		Sumam	e)		
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Ħ.	. Pag tment tant: jury o		'4 ☐ Donation 5 ☐ Other (Specify)	Gat	e of Hea			У	200	05	Silv	er :	Sprin	ı, Ma	rylan
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 Is marked any injury of pages traumatic a pnce.		21. Signature of Funeral Service Licen	Dowl.	1	50	0 Uni	vers	sity E	31vd	Funeral , W, Si	Hom lver	e Tr	10		
			23a. Part1. Inter the disease, or comp. shock, or heart failure. List only of	dications that ca one cause on ea	used the deat ch line.	th. Do not ente	er the mode	of dying	, such as c	cardiac o	r respiratory a	rrest.			Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		s Disea	se								Years	
	Examiner				ras a conseq ine Car										Years	
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (a	i as a conseq	quance oi).									icais	
	and and II-trans	Examiner	that initiated events resulting in death) Last	c. Due to (c	r as a conseq	mence of):								_		
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89	rtificat ng phy as the	ed		d												
Вох	eath certifi attending I for use as	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 Feta	I death 3 🗆	Ectopic prec	gnancy				2		of delive	,	
0	that the der	hysic	1 Yes 2 No	4□Pregna 9□Unknov	nt at time of d vn	leath 5	Other (spec	cify)					Mon	ith	Day	Year
٠ <u>.</u>	s that the ned by a detain	by Ph	Part II. Other significant conditions co	ntributing to dea	ith but not res	ulting in the un	derlying cau	ıse give	n in Part I.		23e. Did to	obacco u	se contri	bute to th	e cause of c	leath?
rds	w requires that been signed to should be det										1 🗆 Y	/es 2[]No -	3 🗌 Prob	ably 4 ^X ⊡l	Jnknown
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	(0)	Con									perfor	rmed? 2 No	de	eath?		ause or
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:				Other			(Check only o				7	
		-	27. Manner of Death	28a. Date of (Month		ER/Outpatient 28b. Time of		2. Injury Work	4 LI Nuis	man a	e 5 🗆 Resid				Assist Livino	
0	Attending Physir death. ector: After this oby the funeral dir	atlo	1 Natural 5 Pending investigation	(MONIT	, Day Year)	Injury	М		? es 2 ∏ N	0					Facil	,
DIVISION	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place o building	f Injury - At ho , etc. <i>(Specif</i>)	ome, farm, stre	et, factory, o	office		2	8f. Location (S City or Tow	itreet and m, State)	Numbe	r or Rurai	Route Num	ber,
_	spital ours a leral C		29a. Certifier 1 Certifying Phy	sician: To the h	est of my kno	wlodgo doath	Danis and at	4h a 4i		- laca e			,			
	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	iner: On the bas and manne	is of examina	tion and/or inve	estigation, in	my opi	nion, death	piace, ai occurre	d at the time, o	date and	and man place, ar	ner as sta nd due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	_			29c. L	icense	number		2	29d. Date	signed	(Month, E	Day, Year)	
	4		1000	aur	W)				D35 7 9	2		Jτ	ıne	6, 2	005	
	.		30. Name and address of person who of													
	Stat	е	Swaroop G. Rao, 31. Date filed (Month, Day, Year)	3 27 Rec	50 W. gistrar's Signa	Edmons	ston [riv	e, Ro	ckvi	lle, Ma	aryla	and			
	Registra		JUN 1 0 20	05	un D	r. Jagos										

		1 - State Registrar		Cei	artment of I <i>rtificate of</i>	Death		Rag. No.	105	21110
	ă	1. Decedent's Name (First, Middle, Las	st)				2. Date of De	ath		3. Time of Death
Physici Medio/		VIRGIE VIRG	GINIA WRI	GHT			June	5, 2	005	9:05P
xamir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Dea	th		ly of Death	
		Casey House			Roc	kville		Mo	ntgo	mery
eral		Social Security Number 6. S	ex 7. Age (In yrs. la		If Under 1 Year Months Days		8. Date of Bir	th v. Year)	9. Birthp	place (State or Fore
tor		218-38-9048	67	Yrs.		110010	May.1	2, 1938	Ma	ryland
		Usual Residence of Decedent 10a, State 10b, County	10c, City	, Town or Lo	ecation				1	0d. Inside City Lin
	ō	MD Montgo	-		ockvill	.e			'	1. Yes 2 □
	ect	10e. Street and Number			10f. Zip Code	4		10 000		
	D	709 Lenmore Av	70 # C-1		2085	٥		10g. Citizen of U.S		ntry?
	Funeral Director	11. Marital Status		13 1			Specify Ves or No		ce - Americ	an Indian
	Fun	1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No			Hispanic Origin? (ean, Mexican, Pue	nto Rican, etc.)	Bla	ack, White,	etc.
	þ	3⊠Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Speci	fy: B	lack
	Completed	15. Decedent's Ed		16a, Deced	dent's Usual Occup	pation		16b, Kind of B	Business/In-	dustry
	ple	(Specify only highest gra	College (1-4or 5+)	(Give life. I	kind of work done DO NOT use retire	pation during most of wo d)	orking	Che	stnu	t
	on	12th		Hou	s ekeepe	r		L	odge	
	Be (17. Father's Name (First, Middle, Last)					me (First, Middle,		,	
	10	Samuel	Brown			Ali	ce Ire	ne Cha	se	
anii l		19a. Informant's Name/Relationship (7	The state of the s			and Number or R				
er tra		Sheila Wright-				on St S	Suitland	d, MD	2074	6
EU.		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location	- City or To	wn, State
24		1 ☐ Nourial 2 ☐ Cremation 3 ☐ 14 ☐ Denation 5 ☐ Other (Specify			sley Ce		5/05	Clar	k s bu:	rg, MD
any injury or other traumatic e		21. Sanaty e of Funeral Service Licen	79 //) 22	. Name and Addre	ess of Facility	nowden	Funer	al H	ome, P.
E 8	-	CORGO F	1109201	1	246 N.	Washing	ton St	Rockv	ille	,MD2085
ician		Immediate Cause (Final		764004177			c or respiratory a	1031,		Onset and Death
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State of Maryland / Department of Health and Mental Hygiene State Registra MEND#7perFH6/13/05, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 1,2005 KENNETH WALKER JUNE 4:46P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day Year) 9. Birthplace (State or Foreign D.Country) 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F Director 578-66-2232 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Director Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20906 4307 Ferrara Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4or 5+) 5+ Dept. of Justice Elementary/Secondary (0-12) Hearing Examiner othar traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Janet Barnes Linnasus B. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Walker- Wife 4307 Ferrara Dr Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State injury or 6/6/05 Silver Spring, MD Gate Of Heaven D ' 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home, P.A. 22. Name and Address of Facility Snowden 21. Signatule of Funeral Service Licensee any 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faillyre. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Inknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 🛂 No 1 ☐ Yes Diractor: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 8, 1001 30. Name and address of person who completed cause of death (Item 23a) Type, Pript) Colesville Rd #310 Silver Spring,MD 840I Mr. Hector Collison, MD 32 egistrar's Signature 31. Date filed (Month, Day, Year) State 1 3 2005 Registrar

			For State Registrar	State of Maryland	/ Department of Health and Certificate of Death			
			Registrar 1. Decedent's Name (First, Middle, Las	t)	Certificate of Deatif	Reg. I	3. Time of	Death
	Physici /Medic		Willie Ho	www	Water		9 05 12:0	DA.M
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				Sing Home	st birthday) If Under Year If Under 24 Hr	\$ 18 Date of Birth	Vorcester	
	Funeral Director		5. Social Security Number 6. Security Number 1	M 20 F 60	Yrs. Months Days Hours Mir		9. Birthplace (State o	r r-oreign
	D		Usual Residence of Decedent	140-07	*	31-10	TO	
	Aaryla I shov	ō	10a. State 10b. County	loc. City,	Town or Location		10d. Inside Cil 1 ∑ Yes	•
	28a-	Director	10e. Street and Number	+CF DNO	10f. Zip Code	10g. (Citizen of What Country?	
	th with	alD	4026 Market	Street	21863		U.S.A	
	er dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. Was Decedent of Hispanic Origin? (It Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
980	urs aft		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 (No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black	
5-0036	72 hours after death with the Maryland natural', or items 23s or 28s-1 show deat Exacilier rout be notified at	Completed by	15. Decedent's Ed	ucation de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of w	orking 16b.	Kind of Business/Industry	
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "netural", or items 23e or 28e-1 show other traumatic event, Ire M. Alcal Exp. till or Livial be notified at	To B	John Hand	lu Waters	Sr. Bern	ice Wo	iters	
Jan	2 sho		19a. Informant's Name/Relationship (1	yar, Print)	19b. Mailing Address (Street and Number or F	Rural Route Number, Cit	or Town, State, Zip Code)	<i>~</i> .
	1 and 2 Health tem 27 l		1/C 1 C C C C C C C C C	(3/57Gr)	ice of Disposition (Name of metery, crematory or other place)	Date 20c.	Location City or Town, State	33
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Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or othe		21. Signatura + Fur eral Service Licen	S00	22. Name and Address of Facility	Francol Ho	oco myrou.	-10 67
	205 2	1	The state of the s	2/01-	P.O. DOX 331	DOCOMORE	City, md. 218	51
			shock, or heart failure. List only of immediate Cause (Final	one cause on each line.	Do not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Betwood and E	ween
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	ing (fter	lon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	
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	To the Hi within 24 To the Fu	Me	29b. Signature and title of certifier	22	29c. License number		Date signed (Month, Day, Year)	
)			•		254422	-	6-9-05	
7.+	1.3		30, Name and address of person who	completed cause of death (Item)	(3a) (Type, Print) Ocomoke, M)	21851		
ľ	Sta		31. Date filed (Month, Day, Year)	32. Pagistrar's Signatu	le hacks			
	Regist	rar	JUN 1 3 2	UUD Diese A	The same of the sa			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 6-10-05 Amend#7.Per FH PCC cr Certificate of Death 00 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year \mathbf{P}^{M} June 2, 2005 6:00 JESSIE MARIE WILLIAMS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's SACRED HEART HOME, INC. Hyattsville 8. Date of Birth (Month, Day, Year)

March 26,1916

9. Birthplace (State or Foreign Country)

Columbia, S.C. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours Months 1 ☐ M 2 🕱 F Yrs. 89 88 579-42-2161 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No **Hyattsville** Maeyland | Prince George's 10g. Citizen of What Country? 10e. Street and Number USA 20782 5805 Queens Chapel Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No **Black** 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) +02 Practical Nurse Private Industry 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Blocker Ethel Kaufman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laurel, Maryland 20708 8747 Contee Road Cornelius Williams/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 6/10/05 Glenwood Cemetery 21. Signature of Funeral Service Litensee 22. Name and Address of Facility Frazier's Funeral Home, Inc. 110132 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Wash., DC 20001 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Failure Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons quence of): Hypertension Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Chronic Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 **X**No 1 Yes 2 No 1 ☐ Yes Stroke 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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Baltimore, Maryland 21215-0036

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ate has been signed by the page 2 should be detached Director: / filled in by

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3 Suicide

(Check only one)

29a. Certifier

Examiner

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within 24 hours a

To the Funeral I

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State Registrar

Dementia

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 🛣 No 27. Menner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title m 2 30. Name and address of person who completed cause a death (

29c. License number D51520

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

a) (Type, Print) Bahram Pishdad, MD

1328 Southern Avenue, S.E. #310 Wash., DC 20032

31. Date filed (Month, Day, Year) JUN 1 0 2005 32. Registrar's Signature

				1 - For State Registrar	State of M		epartment of Certificate of			iene	AE O	000
		Physici		1. Decedent's Name (First, Mi	ddle, Last)	wh	iTTING	7704	2. Date of Death Month	-	Year	e of Death
		/Medio Examin		4a. Facility Name (If not institu HARFORD MEMO	tion, give street and number) DRIAL HOSPITAL		4b. City, Town,	or Location of Death	h CE		of Death RFORD	.7/1
		Funeral Director		5. Social Security Number 215–68–2928 Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last birti 47 Y	Months Days			, ^{Year)} 957	9. Birthplace (Star Country) Marylan	te or Foreign 1d
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		h with the 23a or 28a 1 Le noi	al Director	10e. Street and Number 490 Holly	v Drive	-	10f. Zip Code	21001	10	Og. Citizen of V	Vhat Country?	
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		, <u>, , , , , , , , , , , , , , , , , , </u>		30. Name and address of pers Ramino 31. Date filed (Month, Day, Ye		eath (Item 23a) (T 20, M ar's Signature	ype, Print) HAP	FORD ME	EMORIA	Hosp	PITA 1-1	HAURE
	•	Sta Registr		JUN. 1	0 2005 Keen	a a signation	Total .			•		A SICE

unpend item 224, FIT ype or Print in Black Indelible lnk. Ensure All Copies Are Legible.

ysicia Medic	an J	Decedent's Name (First, Middle, Last					2. Date of D		Year	3. Time of Death
vicuio		KINSEY ALBERT WO		A. TED A	LBERT WO		JUNE 7)5	2:41 P
amin		4a. Facility Name (If not institution, give 4821 LELAND ST	street and number)			or Location of Do	eath		County of Death	
eral ctor		5. Social Security Nu 1401 219–54– 1404 Usual Residence of Decedent	XM alle	(In yrs. last birthday 58 Yrs.	Months Days		Hrs. 8. Date of Bi (Month, D SEPT •	ay, Year)		place (State or Fore ntry) YLAND
핔		10a. State 10b. County	1	10c. City, Town or L	ocation				1	10d. Inside City Lin
Tipe Tipe Tipe Tipe Tipe Tipe Tipe Tipe	ctor	MD MONTGON	MERY	CHEVY C	HASE					1 ☐ Yes 2 X
SU X	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	ntry?
THE STATE OF		4821 LELAND STRE			2081				S.A.	
a l	by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		. Was Decedent of If Yes, specify Cu		(Specify Yes or Nuerto Rican, etc.)		4. Race - Americ Black, White, Specify: WH	
Medical	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	edent's Usual Occi e kind of work done DO NOT use retir	e during most of	working	16b, Kin	d of Business/In	
vent, the Me	Соп		5+	BR	OKER			R	EAL EST	ATE
reumatic even	To Be	17. Father's Name (First, Middle, Last) KINSEY ALBERT WOI					Name (First, Middle DETTE R		Sumame) FLANAGAI	N
reum		19a. Informant's Name/Relationship (T)					Rural Route Numb	er, City or	Town, State, Zip	Code)
thert		SALLY MCGREEVY—GC 20a. Method of Disposition	DRMAN/COUS	LN 1145 20b. Place of Disp		EDWAY, T	UCSON, AZ	857		Chata
eny injury or other tre once.		1 ☐ Burial 2XI Cremation 3 ☐ F		cemetery, cre	matory or other pla	' 1			ation - City or To	
injur,		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens		CUMBERLA	ND CREMA! 2. Name and Addr		16,2005	CUI	MBERLANI	O, MD
eny ir		Ilmand (1)	Lasha 10	14,	UPCHURCE	H FUNERA	L HOME, I	P.A.		
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	lications that caused th	e death. Do not en	202 GREI	ENE STRE ring, such as card	ET, CUMBI	TRLANI	D, MD	21502 Approximate Interval Betweer
		resulting in death)	a. Due to (or as a c	ve Cardiov	ascular Di	SPEE				Onset and Death
ne burial-transit	fical Examiner		b. Due to (or as a c	consequence of):	asular Di	SPR				Onset and Death
as the bur	dicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	consequence of): consequence of): consequence of): pregnancy Fetal death 3[□Ectopic pregnanc			23	d. Date of delive	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Voar **Physician** 9, 2005 3:00 P.M Gawk Yow June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Care and Rehab Center Rockville 8. Date of Birth (Month, Day, Oct. 9, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F Yrs 226-20-5498 89 1915 China Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Montgomery Germantown Director Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 20874 13323 Tivoli Fountain Court United States or Itams 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: Specify: 2 3 Widowed 4 Divorced Asian 1954 "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Civil Engineer Federal Government permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 Is marked other tt any injury or other traumatic avant. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sing Gah Yee Tung-Fung Tam ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shui Ying Yee / Wife 13323 Tivoli Fountain Court Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 18. 20c. Location - City or Town, State 20a. Method of Disposition June 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Geørge Washington 2005 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, Maryland re of Funeral Savice Licensee 22. Name and Address of Facility DeVol Funeral Home 40 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 Months Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physiclan/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ signad Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Ileus Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aortic Aneurysm has autopsy performed certificate 2 X No 1 ☐ Yes 2 ☐ No To tha Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No 2 this 28a. Date of Injury (Month, Day Year) in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending 2 \square No death. investigation M 1 Tes 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b Sidnatus D 28656 June 10, 2005 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Road #208 Rockville, Maryland 20850 Ravi Passi, M.D.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 14 2005

2. Registrar's Signature

			1 - For State Registrar	State of Marylan	-	artment of F		Re	g. No. 2005	21095
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las HELENE 4a. Facility Name (If not institution, give 11909 LEDGEROCK Co	PEGGY ZE	EITLIN	4b. City, Town, o	r Location of De	2. Date of Deat Month JUNE 11	Day Year	
	Funeral Director		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 H Hours M		Q Rid	thplace (State or Foreign buntry) YORK
death with the Maryland	or 28a-f show	Director	10a. State 10b. County MARYLAND MONT 10e. Street and Number	GOMERY	y, Town or Lo	POT(11	Og. Citizen of What Co	
72 hours after death w	ital Hygiene. od other than "naturel", or Items 23a or 28a-f show event, the Medical Examinat must be mulified at	by Funeral	11909 LEDGEROCK CC 11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	DURT 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 No	20854 lispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
ad within	ygiene. ner than "natur it, ine Medicell	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+) 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired SCHOOL	during most of v	LOR		Industry ATION
	i and Mental Hy is marked oth reumatic even	a	17. Father's Name (First, Middle, Last) HYMAN 19a. Informant's Name/Relationship (7	GLASGALL	19b. Mailir	ng Address (Street			Maiden Sumame) DELL SWIG City or Town, State, 2	Zip Code)
mit Pages 1 and 2 sh	Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic ev once.		KIM ARTHUR ZEITLIN 20a. Method of Disposition 1 Surial 2 Cremation 3 Companies 4 Donation 5 Other (Specify	20b. F Removal from State	Place of Dispo cemetery, crer	LEDGEROO sition (Name of natory or other place REMEMBRA	ce)		ARYLAND 2 20c. Location - City or LARKSBURG,	
i i i i i	Departme Importer eny injut		21. Signature of Funeral Service Licen	Judewig	Ĕ. 1	DWARD SAC 091 ROCK	ELFEUNE VILLE P	RAL DIRECT	TION, INC.	20852
	nysician /Medical xaminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (final disease or condition resulting in death)	aMELANOMA Due to (or as a conseq		er the mode of dyin	g, such as card	lac or respiratory arre	st,	Approximate Interval Between Onset and Death 20 YEARS
ate be executed	s s	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d						
the death certificate	attending lor use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
w requires that	been signed by the s should be detached to	by	Part II. Other significant conditions of	entributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		acco use contribute to s 2 🎇 No 3 □ Pr	othe cause of death?
The law	ate has b page 2 sl	Completed							y prior to death? X No 1 □ Yes	utopsy findings available completion of cause of 2 No
Attending Physician: T	rthis ral di	ertification; To Be	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing	Home 5 R Reside 28d. Describe ho	nce 6 Other (Spec	cify)
To the Hospital or Attending	ours after death lerel Director: filled in by the	0	3 Suicide 6 Could not be determined	building, etc. (Specif	(y)			City or Town		
the Hoer	within 24 hours and To the Funerel I completely filled	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Phyone 2 ☐ Medicel Exemple 1 29b. Signature and title of certifier	vsician: To the best of my kno iner: On the basis of examina and manner stated.	tion and/or in	occurred at the tin vestigation, in my o	pinion, death oc	curred at the time, da	use(s) and manner as ite and place, and due od. Date signed (Monti	to the cause(s)
Ī	25		30. Name and address of person who o	completed cause of death (Iten	n 23a) (Tvpe.	MD 765			UNE 13, 20	
	Sta	ate	BRUCE R. KRESSEL, 31. Date filed (Month, Day, Year) 1 5 200		SCONSI		SUITE	1125, CHE	VY CHASE,	MD 20815

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 9100 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 5:35 P M Claudia Zurkin June 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Hours Min 1 ☐ M 2 🖫 F 83 151-30-1191 11/21/1921 Yugoslavia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Prince George's MD Lanham 1 ∏Yes 2 TN No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6305 Princess Garden Parkway 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Library of Congress Marc Editorialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 0706 19a. Informant's Name/Relationship (Type, Print) 6305 Princess Garden Parkway Lanham, Md Michael Zurkin/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/14705 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov from State Nanuet, New York Russian Orthodox ` 4 Donation 5 ☐ Other (Specify) Convemnt Nove DiVccve 21. Signature Philip D.Rinaldi Funeral Service, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heartfailure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Minita Due to (or as a consequence of): endbul

Physician /Medical **Examiner**

Funeral

Director

Show

if item 27 le marked othar then "naturel", or Itams 23a or 28e-f show or other treumatic event, the Medical Ever invertinast be notified at

Pages 1 and 2 should be filed vent of Health and Mental Hygie out; if item 27 le marked othar t

permit. Pages 1 and 2 s
Department of Health ar
Importent; if item 27 le
any injury or other treu

burial-transit attending physician use as the

Physician/Medical þ Completed this certificate has Hospital or Attending after death.

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Accident

3 Suicide

29a. Certifier

4 Homicide

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth

1 Inpatient

2 Fetal death 4☐Pregnant at time of death 9 Unknown

Due to (or as a consequence of)

Corebon Due to (or as a consequence of):

> 3 Ectopic pregnancy 5 Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

23d. Date of delivery Day Month

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes

24a. Was an autopsy perform 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

Year

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Bowic, MD 20120

29b. Signature and title of certifier

29c. License number 10052865

Way

29d. Date signed (Month, Day, Year) 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7502 Quisinherry Michael

Eden

Hospital:

Figaro 2. Registrar's Signature 31. Date filed (Month, Day, Year)

1 3 2005

5 Pending investigation

6 □ Could not be

determined

State

Registrar

within 2 To the

			For State of Mar State Registrar	ryland / Depa <i>Cen</i>	rtment of H			giene Reg. No. 20	05_	21097
	Physicia		1. Decedent's Name (First, Middle, Last) Henry Paul Adamski				June 2	Day 200	Year) 5	3: Time of Dollar
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Charlotte Hall Nursing H		Charlot	Location of Death		4c. County Saint	Maı	4
	Funeral Director		216-16-2799 ¹™ ^{™ 2□} F 8	(In yrs. last birthday) 30 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De) May 1			lace (State or Foreign htry) yland
	Maryland a-f ehow	tor		10c. City, Town or Loc					1	0d. Inside City Limits 1 Yes 2 □ No
	with the	Direc	10e. Street and Number 309 South Chester Stree		10f. Zip Code 21231			10g. Citizen of V United		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be multified at once.	by Funeral Director	11. Marital Status 12. Was Decedent Ev Armed Forces? 1 ★ Never Married 2 ☐ Married 12. Was Decedent Ev Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give	ver in U.S. 13. W		ispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	. ,	e - Ameno ck, White,	an Indian,
21215-0036	within 72 houene. than "nature	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give I Irle. D	DO NOT use retired	during most of work i)		16b. Kind of B		
and 2	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Mental Mental than sumatic event, the Mental than Mental than the Mental	To Be Co	17. Father's Name (First, Middle, Last) Henry J. Adamski	Elect	rician	Carpent 18. Mother's Name Helen E	e (First, Middle,	Maiden Suman		ovement
ے ہے۔ Maryland	12 shoul h and M r is marl raumati		19a. Informant's Name/Relationship (Type, Print)			and Number or Rura	al Route Numbe	er, City or Town,		
) /3/50° Baltimore, N	Pages 1 and ent of Healti nt: If Item 2 ry or other t		Janis Dellospedale-Cousi 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispos	sition (Neme of natory or other plac	June	27,	20c. Location -	City or To	21208 own, Stete , Maryland
3 / Baltii	permit. I Departm Importal eny inju		21. Signature of Funeral Service Licensee Authorized Licensee For Experimental Service Licensee							Approximate 231
	Physician /Medical		23a. Parf1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death)	ne death. Do not ente	ra hal	u nmm	or respiratory and	rest,		Approximate 2.3 I Interval Between Onset and Death
ne 23 nd 3	be executed cian and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	consequence of):	ry Dis	51-J				
D Ju.	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[\sqrt{es} 2 \] No 9 \[\sqrt{Unknown} \] 23c. If yes, outcome or 1 \[\sqrt{Live birth} 2 \] 4 \[\sqrt{pregnant at ti 9} \] Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/			te of delive	ery Day Year
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Adamski of Vital Record	sician: The law re certificate has be irector, page 2 sho	Completed	Dipocision				24a. Was autor perfo 1 Yes	rmed?	Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of 2/2/No
A B.	Physician: this certificatal director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatien	t 2 ER/Outpatien	nt 3 DOA Oth	26. Place of Deat		one) dence 6 □Oth	ner (Specil	(y)
Z G	After Une		27. Manne of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	Wor	y at rk? Yes 2 □ No	28d. Describe	how injury occur	red	
Nenry	= = # e	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injur building, etc.	ry - At home, farm, stre (Specify)	reet, factory, office		28f. Location (City or To	Street and Numl wn, State)	er or Rura	al Route Number,
7	Fur Fur	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state	examination and/or inv	h occurred at the tir vestigation, in my o	me, date and place, prinion, death occur	and due to the red at the time,	cause(s) and made, date and place,	anner as s and due to	stated. o the cause(s)
	To the within 2 To the To the comple	Me	29b. Signature and titlend sertifier		29c. Licens	06/94"	7	29d. Date signe	Month,	Dey, Year)
			30. Name and address of person who completed cause of de Dr. Mathur 29449 Charl	ath (Item 23a) (Type. Lotte Hal		Charlot	te Hal	1. MD	2062	22
	Sta Regist		31. Date filed (Month, Day, Year) 32 Registral			0				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23, 2005 June 6:10AM M Louise Boyd /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Northwest Hospital Randallstown Baltimore Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12–10–38 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🏋 F Yrs. Director N.Carolina 244-56-7174 66 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County it in 27 is marked out 15 is a natural, or items 23s or 28s4 show other traumatic event, the Mudical Examinar must be notified at 1X Yes 2 □ No Director N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA Completed by Funeral 3415 Yataruba DR. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes WNo
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Specify: Black 1 Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Record -Clerk John Hopkin Hosp. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Throckmorton 2 Martha Bagby Spuger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an it of Health Son Melvin Boyd 3415 Yataruba Drive, Baltimore, Md. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) 6/28/05 King Mem.Park Randallstown.Md. 22. Name and Address of Facility
Estep Brothers Funeral Ser, P A
1300 Eutaw Place, Baltimore, Md. 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the dis ase, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Respiratory Failure Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Asthma Exaurbation Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospitet or Attending Physicien: The law requires that the death certificate be executed Asthma Years burial-tran attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 \(\text{Yes} \) 24 \(\text{No} \) Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ completely filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2∑ No 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ER/Outpatient 3□ DOA Certification; To 1 ☐ Yes X☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a Certifier Fo the 29c. License number 29d. Date signed (Month, Day, Year) te of gertifier 29b. Signature and D 0056418 2005 June 23, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Tonya Mason 5401 Old Court Road, Randallstown. Md. 31. Date filed (Month, Day, Xear) **S**gistrar's Signature 32 State & Sparke Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 2005 8:40 A M BRIGHTFUL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Adoutho Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🕅 F 218.26.7193 Yrs. Director 02.17.1932 MD with the Maryland 10a. State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f short Director MD EDGEWOOD 1 Tyes 2 No HARFURD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 1892 GREMPLER MAY USA death Funeral Item 27 is marked other than "natural", or Items other traumatic event, the Medical Examination 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COUNSELOR 121H GRADE 6 YRS HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES SPRUIEL ALICE EDEN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GHINGS (DAUGHER) ANGELA 1892 GREMPLER WAY EDGEWOOD MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If Itel
any injury or oth 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) KING PARK 06.25.05 MD RANDALLSTOWN 21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 BALTO. NATI PIKE, BALTO. MO 21229 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner END STAGE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the attending physicien and thed for use as the burial-tran DSTRIDIUM DIFFICILE COLITIS Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1□ Yes 2 💢 No il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٥ 1 ☐ Yes 2 ☑ No 17 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1814 Mille MO D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MEHTA, M. D. 761/2 32. Registrar's Signature JOGINDER E D 31. Date filed (Month, Day, Year) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 State JUN 2 7 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Bannon lonence W. 2005 June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE HEALTHCARE CATONSVILLE MARINER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09 - 02 - 192 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 🗷 F Yrs. NC 237. 32. 0841 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 □ No BAITIMORE MD NIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 USA PKWY. MIDMOOD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ₺No Specify: If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT HEALTH CARE 12 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WITHERS ANNIE ALEKANDER ALBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4113 BUCKINGHAM RD. BALTO. MD FLORENCE MACK CRAIG Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 06.23.05 BALTO. MO ARBUTUS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE Vaugh 5151 BALTO NATE PIKE BALTO MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic oustric Mouths Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bilateral lower extremity edeuc 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy perform

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is eny injury or other treu once.

Physician

/Medical

Examiner

10a. State

1201

Funeral

Director

or Items 23a or 28a-f show oner must be notified at

1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. em 27 is marked other than "natural", or Iter ther treumatic event, Ite Medical Exertinal

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

death with the Maryland

use as the burial-transit attending physician certificate be Hospital or Attending Physician: funeral director, after death.

Division of Vital Records, P.O. Box 68760

Examine Physician/Medical þ Completed Be

IF FEMALE: 23b. Was decedent pregnap in the past 12 months 1 ☐ Yes 2 ☐ No

1 Natural

2 Accident

4 Homicide

3 🗌 Suicide

29a. Certifier

1☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

5 Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

[Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Other:

4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

2 □ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

MISICIAN

29c. License number D52544 29d. Date signed (Month, Day, Year) June 20, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bentamine S. 7 2005

700 Geige Rd, Suite 204, Catonsville, MD 21228 buit. Registrar's Sig

State Registrar

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			Registrar 1. Decedent's Name (First, Middle,	(act)		Ce	rtificate of	Death		2. Date of D	Reg. N	مد ٥٠٠,		1
	Physicia	an		_		75 . 1 . 1	•			Month	D	ay Yea		
	/Medic Examin		Callie 4a. Facility Name (If not institution,	Eadean	umber)	Batt	1D 4b. City, Town, o	or Location of		June 2		2005 c. County of De	6:12 ar	n'''
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	Funeral			. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		24 Hrs.	8. Date of B (Month, D	irth	9. 8	Birthplace (State or For	reign
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	/anylan	ō					oution.						1 □ Yes 2X	
	or 28a-f	Director	Maryland Balti	more	Es	sex	10f. Zip Code				10a C	itizen of What	Country?	
3	3a or		14 Marie Avenue				21221						,.	
	ier death w Items 23a	Funeral	11. Marital Status		cedent Ever in U		Was Decedent of I	Hispanic Origi	in? (Spec	ify Yes or N			merican Indian,	
	after or Ite	/Fu	1 Never Married 2 Marrie	Armed F d 1 ☐ Yes If Yes, G	2 X No		If Yes, specify Cub 1 ☐ Yes 2 🕱 No		, Риепо н	iican, etc.)		Black, W	hite, etc.	
	"natural", or	d by	3 Widowed 4 □ Divorced	Year or	Dates:]	Specify:	White	
2	"nat	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of workin	g	16b. I	Kind of Busine:	ss/Industry	
4	within with it with it will be it with it with it will be it with it w	duc	Elementary/Secondary (0-12)	College	(1-4or 5+)		maker	(d)			0	Tioms		
2 :	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Mental Hygiene and Mental Hygiene and Mental Families 23s or 28s-f show marked other than "nature" or liems 23s or 28s-f show imatic event, the Medical Examination and the notified and	a)	17. Father's Name (First, Middle, La	ist)		попе	maker	18. Mother	r's Name	(First, Middl		n Home		
		To B	Eddie Cliss	0				Ethe	1	Gist	or			
<u> </u>			19a. Informant's Name/Relationship			19b. Maili	ng Address (Street					or Town, State	, Zip Code)	
,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		Terra Bates (Da	ughter)		14 M	arie Aver	nue Es	ssex	, Mary	land	21221		
2	of He		20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3	Bemoval from		Place of Dispo cemetery, crea	osition (Name of matory or other pla	ce)	/28/2	ate 2005	20c. l	ocation - City	or Town, State	
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8	permit. Departr Importa any inj		21. Signature of Funeral Service Li	censee		22	2. Name and Addre	ess of Facility	eral	Home	РΔ			
	0 D 72 8 04		23a. Part 1. Enter the disease, or co	goff	ing Sr	1	407 Old I	Easter	n Ave	enue	Esse	ex, Mar	yland 2122	1
			snock, or near failure. List of	nly one cause on	each line.	tn. Do not en	er the mode of dyl	ng, such as c	cardiac or	respiratory	arrest,		Approximate Interval Between Onset and Death	
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				tastases	Brain	and	Bone			Years	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brous attend death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical		d Diak	etes Me	llitus	Type Z						Years	
>	leath certific attending p	0	IF FEMALE:	22c If was o	utcome of pregna	2001							1	
2	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	al death 3	Ectopic pregnanc Other (specify)	у				23d. Date of d Month	lelivery Day Year	
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	s that ned b e deta	by Pt	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part I.		23e. Did	tobacco	use contribute	to the cause of death?	?
3	w requires that been signed to should be deta	ed b	Neuropathy Left	Lower E	xtremit	У		·		120	Yes 2	2 No 3	Probably 4 Unkno	วพถ
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	The ate has page	Com								peri	opsy formed? 2 X N	death	o completion of cause ? es 2 \(\subseteq No	OI
2	yeictan: The laviscentificate has director, page 2	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only				
	Phyeic this co	P	1 ☐ Yes 2 XNo		·	ER/Outpatier	IL SEL DOA		sing Hom	e 5∭ Res	sidence	6 □Other (Sp	pecify)	
	ling F	ion:	27. Manner of Death 1 XNatural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time o Injury	Wo			Bd. Describe	how inju	ary occurred		
2	Attending Ph ar death. ector: After th by the funeral	ertification:	2 Accident investiga 3 Suicide 6 Could no	t be	e of Injury - At h	ome farm et	M 1]Yes 2□N		9f Location	(Straat a	nd Number or	Rural Route Number,	
2	atter Direction by	ertii	4 Homicide determin	ed build	ding, etc. (Special	fy)	eet, lactory, office		20	City or To	own, Stat	te)	narar noute realiber,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	aic	29a. Certifier 1 X Certifying	Physician: To th	e best of my kno	owledge, deat	h occurred at the ti	me, date and	f place, ar	nd due to the	e cause(s	s) and manner	as stated.	
	n 24 I	edical	(Check only 2 Medical Ex	kaminer: On the	basis of examina nner stated.	ation and/or in	vestigation, in my o	opinion, death	h occurred	d at the time	, date ar	nd place, and d	ue to the cause(s)	
	To t To tl	M	29b. Signature and title of certifier	0.	1112	M	29c. Licens	se number			29d. Da	ate signed (Mo	nth, Day, Year)	
	9		Mellen	ru	cey	MD	D 54	1749			Jun	e 24, 2	2005	
17)		30. Name and address of person w										21228	
10			Dr. Allen Reill 31. Date filed (Month, Day, Year)		3 Fast Registrar's Signa	Rollin	ng Cross	Road S	Suite	301	Balt	imore,	Maryland	
	Sta Registr		HIN O P 20	100	. logivilai s Sigli	Angs.	E.							

DHMH 17 Rev 1/2001

		•	For Stete Registrar	State of Marylar		tificate of			ene g. N2 N N S	21102
	Physicia	an	1. Decedent's Name (First, Middle, La	ast)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		Pamela Joan 4a. Facility Name (If not institution, given	Beverage ve street and number)		4b. City, Town, o	or Location of Death	June 25	2005 4c. County of Dea	9:25 am ^M
	Lxamii		315 Upperlanding	Road		Essex			Baltimor	re
	Funeral Director			Sex 1 □ M 2 🛛 F 7. Age (<i>lin yrs</i> .	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/10/1		thplace (State or Foreign ountry) cyland
	aryland show d at	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28a-f	Director	Maryland Baltimo	ore Es	sex	10f. Zip Code		10	og. Citizen of What C	
	h with 23a or		315 Upperlanding	Road		21221			U. S. A.	ountry.
	tems	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
5-0036	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: if Item 27 is marked other then "neturel; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination that traumatic event, the Medical Examination that the routified at once.	þ	1 Never Married 2 Married 3 Widowed Midowed	1 □ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2X No			Specify:	nite
215-0	hin 72 hi I. In "netu Vedical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ing	6b. Kind of Business	/Industry
2121	ed witl ygiene ner the it, the	Com	12		Greet	er			Retail Sa	ales
and	d be fill	Be	17. Father's Name (First, Middle, Las	1)				e (First, Middle, N	,	
aryland	should nd Me r mark umatid	^L	Ray Hinkle 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street	ROSA Ma.		⊖Y City or Town, State,	Zip Code)
Ž	and 2 salth a n 27 is		David N. Orr (Ste		315	Upperlan	ding Road	Essex,	Maryland	21 221
Baltimore,	ges 1 it of Hi if Iter or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 [☐Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other pla	^{ce)} 6/28/		Oc. Location - City or	Town, State
볊	it. Pa artmer rtent: njury		*4 □ Dometion 5 □ Other (Spec	by) Bay		rematory Name and Addre		2005	Baltimore,	Maryland
ä	Dep Imp any		Deckary 13	John .	B	ruzdzins	ki Funera	l Home Pi venue E	A ssex. Mary	land 21221
	Physician		Immediate Cause (Final disease or condition	nplications that caused the deal y one cause on each line.	th. Do not ent	er the mode of dyin				Approximate Interval Between, Onset and Death
	/Medical Examiner		resulting in death)	a. Brain Due to (or as a consec	uence of):					10-11.
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	quence of):	cez				
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec						
8760,	icate be executed physicien and s the buriat-transit	dicai E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a consec	(uence or):					
9	tificate ng phy: as the	fedic	15 55 111 5	0.						
Box	death certificate be executed ne attending physicien and ed for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fets 4 ☐ Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	livery Day Year
<u>о</u> .	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions		sulting in the ur	nderlying cause giv	ven in Part I	23e. Did tob	acco use contribute to	o the cause of death?
rds,	w requires that s been signed t should be det	ed by		3	3	, , , , , , , , , ,			_	
0	99	=						1 🗆 Ye	s 2 □ No 3 □ P	robably 4 Munknown
Records,	@ CV	omplet						24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
/ital Recol	cien: The law req ertificate has beer ector, page 2 shou	Be Completed	25. Was case referred to medical examiner?					24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available completion of cause of
Vital	Physicien: The law req this certificate has beer ral director, page 2 shou	To Be	examiner? 1 ☐ Yes 2X No		ER/Outpatien		ner: 4 Nursing Ho	24a. Was an autopsy penform 1 Yes 2 th (Check only one me 5 XResider	24b. Were a prior to death: \[\begin{align*} 24b. Were a prior to death: 1 \begin{align*} 45 \\ 45 \\ 10 \\ 6 \end{align*} 1 \begin{align*} 45 \\ 6 \end{align*} 24b. Were a prior to death: 1 \begin{align*} 6 \begin{align*} 6 \end{align*} 3 \begin{align*} 6 \end{align*} 3 \begin{align*} 6 \end{align*} 3 \begin{align*} 6 \end{align*} 45 \	utopsy findings available completion of cause of s 2 No
Vital	nding Physicien: The law req ath. r: Atter this certificate has beer e funeral director, page 2 shou	To Be	examiner?	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 Nursing Ho	24a. Was an autopsy perform 1 Yes 2	24b. Were a prior to death: \[\begin{align*} 24b. Were a prior to death: 1 \begin{align*} 45 \\ 45 \\ 10 \\ 6 \end{align*} 1 \begin{align*} 45 \\ 6 \end{align*} 24b. Were a prior to death: 1 \begin{align*} 6 \begin{align*} 6 \end{align*} 3 \begin{align*} 6 \end{align*} 3 \begin{align*} 6 \end{align*} 3 \begin{align*} 6 \end{align*} 45 \	utopsy findings available completion of cause of s 2 No
Division of Vital Recor	tor Attending Physicien: The law requalist death. Director: After this certificate has been in by the funeral director, page 2 shou	To Be	examiner? 1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injur	ner: 4 Nursing Hory at rk?	24a. Was an autopy perform 1 Yes 2 h (Check only one me 5 XResider 28d. Describe hor	24b. Were a prior to death? No 1 Yes Other (Spewingury occurred)	utopsy findings available completion of cause of s 2 No
Vital	lospitel or Attending Physicien: 4 hours after death. Eunerel Director: After this certifica ely filled in by the funeral director, p	ical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) Examiner? Note: The control of the	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At h building, etc. (Special hysician: To the best of my knowniner: On the basis of examine	28b. Time of Injury ome, farm, str. fy) pwiedge, death ation and/or in	28c. Injur Wor M 1 [] eet, factory, office	Nursing Hory at tk? Yes 2 No	24a. Was an autopy perform 1 Yes 2	24b. Were a prior to death? No 1 Yes Occurred Deet and Number or R State)	utopsy findings available completion of cause of s 2 No No Notify) ural Route Number, s stated.
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			1 _ State	State of Maryland	•	ent of Health and Nate of Death		000-	_
			Registrar 1. Decedent's Name (First, Middle, Last)		Certifica	ale of Dealif	Reg. 2. Date of Death	COO 0	3. Time of Death
	Physicia /Medic	_	Angelo	S,		ONVEGNA	June 2		
	Examin		4a. Facility Name (If not institution, give s	· 1		ty, Town, or Lecation of Death		4c. County of Dea	. 1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) If Und	der 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	ANNE 9. Bir	thplace (State or Foreign
ı	Director		212-09-3862	M 2□F 8	Yrs. Month	s Days Hours Min.			(ARY/AND
	/land	}	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	2			10d. Inside City Limits
	Be-feh	ctor	MARY/AND ANNE	ARUNDEL		deNA			1 □Yes 2 No
	with the Maryland to or 28e-f show	Funeral Director	10e. Street and Number	1010	10f.	Zip Code 2 11 2 7	10g.	Citizen of What Co U - S	
	ms 23	nera	1904 RINGS D	2. Was Decedent Ever in U.S Armed Forces?	. 13. Was De	cedent of Hispanic Origin? (Sp pecify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	erican Indian,
30	hours after tural', or ite al Exemina	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		25 No Specify:	rricall, etc.)	Black, Whit	Shite.
5-0036	d within 72 hours after death with the Marylan Jiene. r then "natural", or Items 23a or 28e-f show Itte Medical Examiner must be notified at		15. Decedent's Educ	ation	16a. Decedent's U	sual Occupation	. 16b	Kind of Business	
212	within 7 ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	-2 4	work done during most of work use retired)	ing	Beth	SteeL
2 2	filed w Hygier Ather th	e Co	17. Father's Name (First, Middle, Last)		246	18. Mother's Nam	e (First, Middle, Maid	len Sumame)	
<u>a</u>	Mental Mental rrked o	To Be	SALVATORE	Bon	IVEGNI	7 UNK			
Mary	s 1 and 2 should Health and Mer Item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Addre	ess (Street and Number or Rui	1 010	y or Town, State,	Zip Code)
-	Health tem 27 other t		20a. Method of Disposition	29 NA 20b. Pla	ace of Disposition (f	KINGS DENC	Date 20c	Location - City or	Town, State
altimore	Pages ment of sent: If I		1 → Surial 2 □ Cremation 3 □ Re 1 → 4 □ Donation 5 □ Other (Specify)	emoval from State	motory, cromatory c	Cence Cen June	27 700 E	SAHIMO	re MARYAND
Balt	ermit. Pepertn nporte ny inju	1	21. Signature of Funeral Service License	е	22. Name	and Address of Facility	NINO J		en Home
	405 e a		23a. Part1. Enter the disease, or amplic shock, or hear failure. List only on	cations that caused the death.	- 263	S. CONKIN	5 57. 51	7/to M	Approximate
	Physician		shock, or head failure. List only on Immediate Cause (Final disease or condition	e cause on each line.		EU MON, A			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as/a conseque					6MOS
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):				6110)
	nd nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
8760,	ate be executed sysician and he burial-transit	cai Ex	resulting in death) Last	Due to (or as a conseque	ence of):				
/89	ate he	ᇴ	d						
ROX	eath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnant 1 Live birth 2 Fetal of	death 3 □Ectopic	pregnancy		23d. Date of de Month	livery Day Year
0	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5 ☐ Other	(specify)			,
ຕັ	law requires that the as been signed by th 2 should be detache	by Pr	Part II. Other significant conditions con	tributing to death but not result	ting in the underlyin	g cause given în Part I.	23e. Did tobacc	o use contribute to	o the cause of death?
ecords,	w requires t been signe should be		11/1/	^			1 🗆 Yes		robably 4 Unknown
Rec	0 5 0	Completed	DIABETE	>	, ,		24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
Vital	sicien: Th certificate irector, pag	Be Co	25. Was case referred to medical examiner?			26. Place of Deal	1 ☐ Yes 2 ☐ th (Check only one)	No 1 □ Yes	3 2 No
ot <	Physicien: this certific ral director,	2	1 Yes 2 No H		R/Outpatient 3				ocify)
	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Division	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fac	ory, office	28f. Location (Street City or Town, St		ural Route Number,
	e Hospitel or Al 24 hours atter of Funerel Directetely filled in by		29a. Certifier + Certifying Phys	ician: To the best of my know	death occur	and at the time, date and place	and due to the cause	v(c) and manner as	c ctated
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	on and/or investigat	ion, in my opinion, death occur	red at the time, date	and place, and due	e to the cause(s)
	To the within To the comple	M	29b. Signature and title of certifier)_4.		29c. License number		Date signed (Moni	
	~		Trum Joh	moleted cause of death (It-	23a) (Tuno Briet)	021438	9	une 70	12001
Í	0		MIC(FAD J. C	mpleted cause of death (Item 2	45 DEFE	ISE HIGHWAY	ANNAPa	is MD	21401-5559
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 7 2	32. Registar's Signatu	H. Aos	021438 ISE HIGHWAY			
			JUNA 1	, coo	- /-/				

State of Maryland / Department of Health and Mental Hygiene

5. v			For State Registrar - 1. Decedent's Name (First, Middle, Last				tificate o	f Death	2. Date of De	Reg. No	°2005	3 Time of Delith
	ysicia Medic		Margaret		Μ.	C1	auser		June	23.	2005	10: 16 p M
	amin	_	4a. Facility Name (If not institution, give	street and number)				, or Location of Death	0 0110	1	. County of Death	
			235 Glyndon	Drive			Rei	sterstown			Baltim	ore
Fun	eral		5. Social Security Number 6. S	7. Ag	θ (In yrs. last	birthday)	If Under 1 Year	ar If Under 24 Hrs.	8. Date of Bir	th	9 Birth	hplace (State or Foreign
Dire	_		216-14-8350	MXXXXX	83	Yrs.	Months Day	s Hours Min.	Month, Da	1 <i>y</i> , <i>rear</i>	21 Ma	ryland
D			Usual Residence of Decedent									7====
rylar	可		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
a Ma	ilies	cto	MD Baltim	ore			Reister	stown				1 ☐ Yes 21 No
death with the Maryland ms 23s or 28a-f show	1 P	Director	10e. Street and Number				10f. Zip Code	•		10g. C	tizen of What Co	untry?
17 wil	T I	<u>a</u>	235 Glyndon Dr	ive			21	136			U.S.A.	
dea	E.	Funeral	11. Marital Status	12. Was Decedent 1 Armed Forces?	Ever in U.S.	13. V	Vas Decedent o	f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No)-	14. Race - Amer	
after or its	1		1 Never Married 2 Married	1 ☐ Yes 2 🛣 h	No				rican, etc.)		Black, White	e, etc.
72 hours after natural', or Ita	ledical Exactives must be nutitied at	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			□Yes 2½DN	10 Ѕреспу:			Specify:	White
72 hc	lica.	Completed	15. Decedent's Ed (Specify only highest gra	lucation	1	6a. Deced	lent's Usual Occ	cupation	ina	16b. F	(ind of Business/l	Industry
within iene. than "	¥	de l	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	OO NOT use ret	ne during most of work ired)	n ig			
gien gien	4	20	12			H	omemake	r		70	n Hom	e
ld be filed ental Hygie kad othar	evant, the M	Be (17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle	, Maidei	n Sumame)	
2 should be and Mental	tic e	2	Ross Ell	iot Prito	chard			Mi	ldred	Got	ıgh	
sho N but	amn		19a. Informant's Name/Relationship (Type, Print)	1	19b. Mailin	g Address (Stre	et and Number or Run	al Route Numb	er, City	or Town, State, Z	ip Code)
nd 2 st alth and 27 Is n	r tra		Mildred M. Tenne	y Daught	er 2	2212	Cedar H	ill Drive	Finksb	urg	MD 210	048
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked	otha		20a. Method of Disposition	,	20b. Place	of Dispos	sition (Name of		Date		ocation - City or T	
ages not of	y or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				natory or other p	1	105	0		MD
permit. Pages 1 a Department of Hea mportant; If item	njur.	}	21. Signature of Funeral Service Licer		Garr			is Cem $6/28$ dress of Facility 118			ngs Mill	
Depid	any		1		/-			NERAL HOME			own, MD	21136
Certificate be executed Exam ding physician and	iner inertransit	Medical Examiner	23a. Part 1. Enter the dide 19, or dem shock, or heart failure. List of y Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	a. Sudde Due to (or as	a consequent	ce of):	recten					Interval Between Onset and Death
death certif	80	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetel de	ath 3 🗌	Ectopic pregnar Other (specify)				23d. Date of delik Month	very Day Year
requires that the	e det	^	Part II. Other significant conditions o	ontributing to death b	ut not resultin	g in the un	iderlying cause	given in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
quire in sig	q pi								10	Yes 2	₽No 3□ Pro	bably 4 Unknown
law requires as been sign	sho	ompleted							24a. Was	an	24b. Were aut	opsy findings available
0 5	page 2	E C							auto	osy ormed?	prior to co	ompletion of cause of
ilcian: Th	r, pa	O.	06.00							e No	1 ☐ Yes	2 No
ician: T		Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Death				
	-	ertification; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui		Outpatient b. Time of Injury	28c. In W	Other: 4 Nursing Holipry at Yes 2 No	me 5 Resi 28d. Describe			ify)
A C O	completely filled in by th	O	3 Suicide 6 Could not be determined	building, etc	c. (Specify)				City or To	wn, State	9)	ral Route Number,
Hosp 24 hou	itely fi	edical	29a. Certifier Certifying Ph (Check only 2 Medicel Exen	niner: On the basis of	examination	dge, death and/or inv	occurred at the estigation, in my	time, date and place, opinion, death occurr	and due to the ed at the time,	cause(s date an) and manner as a d place, and due	stated. to the cause(s)
To the within 2	mple	Med	one)	and manner sta	ited.							
다. IN C	8		29b. Signature and title of certifier	1 - 1			05	nse number			te signed (Month	
d	Y		MANIA	~	0		D a	25062		6	27/20	05
6	1		30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type, I	Print)	27062 ct, Reist				
U			GARY A MAN		750 1	MAI	n Stra	IT, KEIST	wor est	10,	MO 2113	36
Re	Sta egistr		31. Date filed (Month, Day, Year)		ar's Signature	S	arte					

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Maryland / Department of He	
1 - State Certificate of D	Death
Decedent's Name (First, Middle, Last)	2. Date of Death
Frank B. Corrall	June 23,2005 21:55 PM
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or I	
Sinai Hospital of Baltimore Baltim	ore City n/a
5. Social Security Number 234–26–8318 6. Sex 1 XM 2 F 85 Yrs.	If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 3, 1920 9. Birthplace (State or Foreign Country) W.V.
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location Randallstown	10d. Inside City Limits 1 □ Yes 2 🖔 No
10e. Street and Number 10f. Zip Code 2113	10g. Citizen of What Country? USA
11. Marital Status 1	panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) Specify: 14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupal (Give kind of work done diffe. DO NOT use retired)	tion 16b. Kind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) Pay Master	Air Nat. Guard
17. Father's Name (First, Middle, Last) Dominick Corrall	18. Mother's Name (First, Middle, Maiden Sumame) Maria Corrall
19a. Informant's Name/Relationship (<i>Type, Print</i>) Bernard Corrall son 19b. Mailing Address (<i>Street as</i> 5544 Silver	nd Number or Rural Route Number, City or Town, State, Zip Code) Spur St. Boise Idaho 83709
20a. Method of Disposition 1 ☒ Burial 2 □ Cremation 3 □ Removal from State 1 ☒ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cametary, crematory or other place Sacred Heart of Disposition (Name of cametary), crematory or other place Sacred Heart of Disposition (Name of cametary), crematory or other place Sacred Heart of Disposition (Name of cametary), crematory or other place of Disposition (Name of c	
22. Name and Address Connelly Fu 7110 Soller	ineral Home Of Dundalk s Point Rd. 21222
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	, such as cardiac or respiratory arrest, Approximate Interval Between
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
resulting in death) Last C. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I. 23e. Did tobacco use contribute to the cause of death?
Hypertension, Diabetes Mellitus, Coronary Arten	1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown
Disease	24a. Was an autopsy performed? 1 Yes 2 No 1 Pes 2 No
25. Was case referred to medical	26 Place of Death (Check only one)

the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for I

Physician

/Medical Examiner

> resulting in deat IF FEMALE: 23b. Was deced Part II. Other sig Hyperter Drsease 3 🗌 Suicide

4 Homicide

Physician

/Medical

Examiner

Funeral Director

Completed by

To Be

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Medical Evaninar must be notified at appear.

Baltimore, Maryland 21215-0036

Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated eve Examiner Physician/Medical Completed by Be 2 Certification: 29a. Certifier (Check only one) Medical

State Registrar

25. Was case re examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined

Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

RES-000

29d. Date signed (Month, Day, Year) June 23,2005

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year) JUN 2 7 32. Pagistrar's Signature

2005

			1 - For State Registrar	State of Maryland	d / Department of I Certificate of			ne 2005	21106
	Physici		1. Decedent's Name (First, Middle, Last)		Carle	,	2. Date of Death Month	Day Year 2 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		Location of Death	June a	4c. County of Death	111707
	Funeral Director		5. Social Security Number 6. Sex	7. Ago (In yrs. In		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign try) YLANA
	e Maryland 8a-f show Illind at	Director	10a. State 10b. County	MORE 10c. City	Parkvill	P		11	0d. Inside City Limits 1 ☐ Yes 2 No
	eath with th	Funeral Dire	10e. Street and Number 11. Marital Status	Ford Rd.	10f. Zip Code	1234 dispassio Origina (Spoo		Citizen of What Coun	
9003	within 72 hours after death with the Maryland ene. than "netural", or Itams 23e or 28e-f show the Medical Extentional Legical and	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13. Was Decedent of I If Yes, specify Cub		Rican, etc.)	Black, White,	
21215-0036	be filed within 72 ho ital Hygiene. id other than "netu evant, tre Meulcal	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	16a. Decedent's Usual Occuj (Give kind of work done life. DO NOT use retire	pation during most of workir d)	ng 16b	o. Kind of Business/Ind	ustry
Maryland	2 should be filed and Mental Hygis is markad other aumatic evant, ii	To Be C	17. Father's Name (First, Middle, Last) UN KNOWN	On the last		18. Mother's Name	JOWN		
	t and Health tam 27 othar ti	10	19a. Informant's Name/Relationship (Type) 20a. Method of Disposition 1 Reurial 2 Cremation 3 Re	etar 20b. Pl	19b. Mailing Address (Street 14 3 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e Terrace	Cost, B	ty or Town, State, Zip Location - City or To	2105
Baltimore	permit. Pages Department of I Important: If its any injury or o		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Dok	ance Valley Mone	Cardens 6	TIMONIUI	nMD 210	<i>73.</i>
	rnysician		23a. Part1. Enter the disease, or complice shock, or heart failure. List dnly on Immediate Cause (Final disease or condition	ations that caused the death	n. Do not enter the mode of dying.	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a consequ				71.00	
8760,	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	Due to (or as a consequ					
.O. Box 687	death certifi e attending d for use as	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnance	у		23d. Date of deliver	ry Day Year
Ω.	The law requires that the tee has been signed by the sage 2 should be detached.	ed by Ph	Part II. Other significant conditions conf	ributing to death but not resu	llting in the underlying cause gr	ven in Part I.		co use contribute to the	(
Vital Records,		Completed	OS W				24a. Was an autopsy performed 1 Yes 2	2 death?	psy findings available apletion of cause of
Division of Vit	a th	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of eath 1 Natural 5 Pending 2 Accident investigation		ER/Outpatient 3 DOA Oth	v at 2	(Check only one) 16 5 Residence 18 Residence 18 Residence		ASSISTED LIVING.
Divis	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)			City or Town, St		
	To tha Hospital or within 24 hours afte To tha Funeral Dir. completely filled in I	Medical	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	wledge, death occurred at the tii ion and/or investigation, in my o	me, date and place, as pinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as sta and place, and due to	ited. the cause(s)
	withi To t	Σ	29b. Signature and title of certifier		29c. Licens	e number		Date signed (Month, D	
17	7	1	. 10 30 -	inpleted cause of death (Item		U377 CS		une 24	21230
	Sta Registr	-	31. Date filed (Month, Day, Year) JUN 2 7 2005	2. Registrar's Signatu	Hospital Prof. Bu	elding Em	303 Balk	imore MD	<12>1

State of Maryland / Department of Health and Mental Hygiene

					,	Cen	tificate of	Death	,	Reg. No.)	0.0	01.5
			1. Decedent's Name (First, Middle, La	ist)					2. Date of De Month		Year	(3. Time of Death)
	Physici /Medio		WILLE	CLARI	<				JUN		2005	7.00 PM
	Examir		4a Facility Name (If not institution, given			1		4b. City, Town, or Lo				
4			FUTURE CARE	SANDT	0W	~		BALTIMO		BALTIM	me	C117
li	Funeral Director		218-07 8163	Sex, 7. Age	(In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, De		9. Birthpi Coun	lace (State or Foreign try) NC
	D >	'	Usuel Residence of Decedent 10a. State 10b. County		10c City	y, Town or Loc	etion				11	0d. Inside City Limits
	works.	<u>,</u>	MD NA			JIMORI					1.	1 EN-Yes 2 □ No
	th the Meryle or 28a-f shore on putted at	ğ			DHL	JIMOR	7			10g. Citizen of	Afbat Cour	tn/2
	23a or 2	Funeral Director	701 N . ARLING	TON AVEN	JUE		10f. Zip Code 212	17		ı	ISA	
	ep .	ne l	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U,	S. 13. W	as Decedent of I Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. Rac Bla	ck, White,	
9036	filed within 72 hours after death with the Meryland Hygiene. Iffer than "naturel", or thems 23a or 28a-f show ent, the Medical Examinat must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 💁 N If Yes, Give Year or Dates:	lo	1	□Yes 2M2No	Specify:		Specif	» BLAC	!K
5-0	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation ede completed)		16e. Decede (Give k	ent's Usual Occup	oation during most of work d)	ing	16b. Kind of B	usiness/Ind	lustry
2	ithin and and and and and and and and and an	횰	Elementary/Secondary (0-12)	College (1-4or 5	+)					2010	20	. Out
2	y Se tr	3	6TH GRADE	NA		MIHIM	ENANCE	18. Mother's Name	(Final Stratation	BALTO.		L SYSTEM
Ē	d off	8	17. Father's Name (First, Middle, Last)					e (First, Middle	, Maiden Sumai	ne)	
yla	Men Men	2	TOMMIE CLARK			,		HELENA				
<u>a</u>	2 sh end is m	- /	19a. Informant's Name/Relationship	•				and Number or Bure				.022
6	and leelt m 27		LOUIE DELL CLA	PK	20h B		ition (Name of	GTON AVI	∠. BA	20c. Location		217
Baltimore, Maryland 21215-0036	parmit. Peges 1 and 2 should be filed withir Depertment of Heelth end Mentel Hygiene. Important: If tem 27 is marked other than eny Injury or other traumatic event, the Mannes.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Speci		C	odlawi	atory or other pla			BALTO.		wii, State
Balt	parmit. Depertimportuenty Injury Inju		21. Signature of Funeral Service Lice	nsee				REENE FL NATE PIKE,	_		5 1229	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused	the death					* -*-		Approximate
	Physician		snock, or neart failure. List only	one cause on each lin	10.						1	Interval Between Onset and Death
4	/Medical		Immediate Cause (Final disease or condition	META	STA	TIC	CANC	ER OF	= Pros	TATE	1	
	Examiner		resulting in death)	a		r as a consequ						
		ner				ENTI					;	
	be axecuted siclen end buriel-trensit	edicai Examiner	Sequentially list conditions,	b	Due to (o	r as a consequ	ience of):					
Ő,	e axe	<u> </u>	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	NE	C120	TIL	HEE L	ULCE	R			
68760,	icate b physic s the b	dica	that initiated events resulting in death) Last		Due to (or	ras a consequ	ence of):				1	
-	laath cartifica attending ph d for use es t	ě		d	11	IEMIA	4				1	
Bo	th ca tend	an	_	d								
O. E.	the at the at	sic	Part II. Other significant conditions	contributing to death bu	ıt not resi	ulting in the un	derlying cause gi	ven in Part I.	23b. Did	tobacco use co	entributa to	the cause of death?
Ρ.	hat the daath co ed by the attend detached for us	F.	ARTHRITIS						10	Yes 2□ No	3 🗆 Prot	bably 4 Unknown
Ś	as the signed be de	by									045 14/-	are autopsy findings
Division of Vital Records, P.O.	The law requiras that the daath cartificate be axecuted at a has been signed by the attending physicien end paga 2 should be detached for use es the buriel-trensi	Completed by Physician								en eutopsy ormed?	ava	ailable prior to mpletion of cause death?
æ	has ga 2	E								Van 2006		_
a	n: The	ပိ	DS 18fee area referred to medical	1				00 81 (8		Yes 2010	1	Yes 22 No
ξ	certif	Be C	25. Was case referred to medical examiner?	Hospital:	-4 0 0	FD/O-4-44-44	o⊓ post Ot	26. Place of Deatl her: 42 Nursing Ho			(С:4	.)
of	Phys this rald	Ĕ	1 Yes 2 No 27. Menner of Death	1 ☐ Inpatie		ER/Outpatient 28b. Time of				how injury occu		//
L _O	After fune	F	1 Netural 5 ☐ Pending	28e. Dete of Injur (Month, Da)	(Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2 ⊟No				
İSİ	Attendent deet ctor:	fica	3 Suicide 6 Could not b	28e. Plece of Inju	ıry - At ho	ome, farm, stre	et, factory, office		28f. Location (Street and Num.	ber or Rura	l Route Number,
á	after Dire	er	4 ☐ Homicide	building, etc	. (Ѕресп)	V)			City of 10	wn, Stete)		
	To the Hospital or Attending Physician: The is within 24 hours after deeth. To the Funeral Director: After this certificata ha completely filled in by the funeral diractor, paga	edical Certification: To		nysician: To the best of miner: On the basis of and manner sta	examinat	tion and/or inve	estigation, in my	opinion, death occurr	ed et the time,	date and place,	and due to	the cause(s)
	o the o the omple	¥	29b. Signatere and title of certifier				29c. Licen	se number		29d. Date signe	ed (Month, i	Day, Year)
	- SFO		P	RIMM27 C	ARE		Do	56948		JUN	18	2005
	N		30. Neme and address of person who	completed cause of de	eath (Item	23a) (Type, F	Print)	se number 51948 EET B	ALTIMM	E MO	217	217
	Sta		31. Dete filed (Month, Day, Year) JUN 2 7 2005	32. Registra	ar's Signa	ture sport	W.	10				
	Registi	ar	JUN 2 / 200.	1								

	1 - State of Maryla Registrar	and / Department of Health and N Certificate of Death	Mental Hygiene
Physician	Decedent's Name (First, Middle, Last) Sean	Davis	2. Date of Death Day Year June 21. 2005 3. Time of Dath 5:35 a
/Medical Examiner	4a. Facility Name (If not institution, give street and number) University Hospital	4b. City, Town, or Location of Death	
Funeral Director		vrs. last birthday) Yrs. Houter 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) July 15,1973 Maryland
show	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location Middle	10d. Inside City Limits River 1 □ Yes 2 ☒ No
with the Mar a or 28a-f si Le notified Director	Maryland Baltimore 100. Street and Number 23 Oak Grove Drive Apt.	10f. Zip Code	10g. Citizen of What Country?
hours after death with the Maryland tural', or Itams 23a or 28a-f show at Examinational be notified at ad by Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	n U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2★★No Specify:	United States Decify Yes or No- Palican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
et a 2	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ring 16b. Kind of Business/Industry
be filed within tal Hygiene. d other than avent, It. Mu	G . E . D . 17. Father's Name (First, Middle, Last)	Truck Driver 18. Mother's Nam	Trucking Industry e (First, Middle, Maiden Sumame)
es 1 and 2 should be filed of Health and Mental Hygic if item 27 is marked other or other traumatic avent.	Robert M. Davis, Sr. 19a. Informant's Name/Relationship (Type, Print) Wife	19b. Mailing Address (Street and Number or Run	uise Bradley ral Route Number, City or Town, State, Zip Code)
heal an	Mrs. Jennifer F. Davis 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State		pt. A Middle River, MD 21220 Date 20c. Location · City or Town, State
permit. Pages 1 at Department of Hea Important: If itam any injury or othe		Alltop Service Corp. 6/25 22. Name and Address of Facility Duda-Ruck Funeral	/2005 Towson, Maryland Home of Dundalk, Inc.
20 E # 9	23a. Part. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	7922 Wise Ave. Du	andalk, Maryland 21222 or respiratory arrest, Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a	ultiple injustices	Onset and Death
Je L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	escus ros cif	
cate be executed physician and the burial-transit dical Examir	that initiated events resulting in death) Last	sequence of):	
death certifi e attending I d for use as iclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pre 1 Live birth 2 Fegnant at time of	etal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
es the igne be o	Part II. Other significent conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown
W TT 18			24a. Was an autopsy findings available prior to completion of cause of death? 1 1 Yes 2 \sum No 1 Yes 2 \sum No 1 No 1 No 2 No 2 No 2 No 2 No 2 No 2
Phyaician: The this certificate ral director, pag. To Be Cor.	25. Was case referred to medical examiner? X☐ Yes 2☐ No Hospital: 1 X Inpatient 2 27. Manner of Death 28a. Date of Injury	Othor	h (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
ital or Attending Physics after death. al Diractor: After this led in by the funeral di	1 □ Natural 5 □ Pending (Month, Day Year, 2 ↑ Accident investigation 6 - 2 (- 2)	7 Injury Work? 4>40 AM 1□Yes 2 ANO	Driver of motor vahide lost controlled 2-3 time was ejected 281. Location (Street and Number or Rura Route Number, City or Town, State) 1 095 and North point in D
he Hospi in 24 hou he Funar pletely fill edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my leading the control of the basis of examiner: On the basis of examiner and manner stated.	knowledge, death occurred at the time, date and place, nination and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
with To t	29b. Signature and title of certifier M M M T M T M T T T T T T	29c. License number OCME	29d. Date signed (Month, Day, Year) June 21, 2005
5	30. Name and address of person who completed cause of death (I	111 Penn Street	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature Signa	the Speries	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician UMONI 221 -00pm 0 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** SOUTH ROSEDALE STREET BALTIMORE NA 8. Date of Birth (Month, Day, Year 08 · 21 · 19 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 1 F 259.46.2067 13 Yrs GA Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ahow the Medical Examiner must be notified at 1 LYes 2 □ No Completed by Funeral Director NIA MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET SOUTH ROSEDALE USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 MENo Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: BLACK Specify: 3 KWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene. 27 is markad other than "I r fraumatic avant, The Med Elementary/Secondary (0-12) College (1-4or 5+) FACTORY NA WORKER 11 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H itam 27 is markad ott r othar traumatic avan Be JULIUS JONES MAMMIE ဂ္ဂ SIMMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 REXMORE RD., BALLO. RUTH DRUMMOND- MOORE MD 21218 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ŏ 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. = 5 4 □ Donation 5 □ Other (Specify) BEST GATE MEMORIAL 06.25.05 ANNAPOLIS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUVERAL SERVICE 5151 BALTO NATE PIKE, BALTO. MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Box 68760. use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 44 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan page 2 autopsy performed? 2 No 1 ☐ Yes To the Hospital or Attanding Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) ို 1 Tes 2 🔁 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural s after dec. 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours a To tha Funaral C completely filled pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0 ame and address of person who completed cause 00

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year,

JUN 2 7 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Bernard Berardino DiPasquale, 2005 Jr. June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3717 Gough Street Baltimore n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1**⊠** M 2□ F Director 219-18-8979 78 Maryland 7-4-1926 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Baltimore Director 1X Yes 2 □ No n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3717 Gough St. Baltimore 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No Navy If Yes, Give Year or Dates:₩WII Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "r any injury or other traumatic event, Ir a Med 20168. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Conrail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Berardino DiPasquale Augusta Frasca 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Palmer DiPasquale 3717 Gough St., Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/27/2005 Baltimore, Maryland `4 ☐ Donation 5 ☐ Other (Specify) Oaklawn 22. Name and Address of Facility Joseph N. Zannino Jr.FH 263 S. Conkling St. Baltimore, MD 21224 21. Signature of Funeral Service Licensee Zanneno Maria 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death, Immediate Cause (Final Physician Congestive Heart disease or condition resulting in death) yea/s /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate this set of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit To the Hospital or Attending Phyaician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) certificate 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Injury 1 ANatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) (gottlieb 22 5. 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2-62005 /Medical 4a. Facility Name (If not institution, give street and 4c. County of Death Examiner Owings Mills Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 220-74-5745 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1X Yes 2 No Director City **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6711 Park Heights Avenue Apt. 310 21215-2440 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None None permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item Z7 is marked ofth any injury or other traumatic event, 900ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred H. Flounders Jr. Margaret Vordemberge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank L. Flounders Brother 6711 Park Heights Avenue Apt 310 Balto, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery | 6/29/2005 Pikesville, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 am 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Driset and Death shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Physician/Medical Se attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSEWOOD 31. Date filed (Month) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner DICE Under 1 Year | If Under 24 F More Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1 MM 2□F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at Maryland 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? .0 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 sho Id be filed within 7 h and N ental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be mino Department of Health and Important: If item 27 is me any injury or any 19a. Informant's Name/Relationship (Type, Print) (W.fe.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ F

4 □ Donation 5 □ Other (Specify) 3 □Removal from State 2005 edar Name and Address of Facility 21. Signature of Funeral Service Licensee ph L. Kuss Funeral Home P.A. 2 W. North Ave. Balto. Md. 21216 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic rostate Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D25205 2005 no 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) our C 31. Date filed (Month, Day, Year) . Registrar's Signature State JUN 2 7 2005 Registrar

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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only 2 Medical Examiner: On the basis of examination at	e, death	occurred at the tim	e, date and	place, and due	to the caus	e(s) and mar	nner as st	ated.
	the H	Medi	one) and manner stated. 29b. Signature/and, title of certifier	10201111	29c. License				Date signed		
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			For	State of Marylan				Mental Hyg	giene		
			1 - State Registrar		Ce	rtificate of	Death		leg. No. 2 ()	05	21111
	Physici	an	1. Decedent's Name (First, Middle, La	-				2. Date of Dea Month	Per	Year	5Tinle of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b City Town o	or Location of Deat	JUNE 3	4c. County	of Death	2.30
	Examin	er	NORTHWEST HOSPI			RANDALL			BALTI		
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. I	last birthday)		If Under 24 Hrs Hours Min.	8. Date of Birth			place (State or Foreign
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	r 28a	Director	10e. Street and Number	,	2111010	10f. Zip Code		1	l0g. Citizen of V	Vhat Cour	ntry?
	death with the Maryland ms 23a or 28a-f ahow		3411 MANOR HILL	ROAD		21208			U.S.A.		
	tams	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Rac Blac	e - Americ	ean Indian, etc.
30	within 72 hours after ene. than "natural", or Ita	by Ft	1 Never Married 2 Married 3 Midowed 4 Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1	1□Yes 2No	Specify:			U.S.	.A.
212-0036	tural		15. Decedent's E		16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	siness/In	dustry
212	hin 72 in "ne Medii	piet	(Specify only highest gra		(Give	kind of work done DO NOT use retire	during most of wo	rking			
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and	should be filed within 72 hours after death with the Marylan of Mental Hyglene. marked other than "natural", or Itams 23a or 28a-1 ahow matic event, its Madical Exacilinational its intilifical at	Be	17. Father's Name (First, Middle, Last,	1	14	EMBER		me (First, Middle, I	Maiden Sumam		IEDMAN.
<u> </u>	d Men d Men narke	1º	LOUIS	T		EMPER	IDA				HERMAN
Z Z	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er ones.	1 2	19a. Informant's Name/Relationship (-		ural Route Number - BALTIM		-	
a)	Heal Heal tem 2		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of			20c. Location -		
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ñ	Depa Depa Impo any ir		1 and					ROAD - P			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arm	est,		Approximate Interval Between
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	nted I Insit	mine	cause. Enter Underlying Cause (Disease or injury that initiated events		34						
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X Q Q	 requires that the death certiful been signed by the attending ishould be detached for use as 	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live birth 2 Fetal	Ideath 3[Ectopic pregnancy	,		23d. Dat Mor	e of delive	ory Dav Year
5	the deay the a	ysic	1 ☐ Yes 25 No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (specify) _			10101		ouy rour
7.	that the ed by detact		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	bacco use contr	ibute to th	ne cause of death?
Records,	requires that een signed b nould be deta	d by						1 □ Ye	es 2□No	3 🗆 Prob	ably 4 Munknown
Ö	law rec as bee 2 shou	ompieted						24a. Was a	n 24b. V	Vere auto	psy findings available
	iician: The lav certificate has rector, page 2							autops perform	med?	eath?	npletion of cause of 213 No
VItai	ysician: is certifica director, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only on	74.1		-77.10
010	y s	To I	1 ☐ Yes 2 No		ER/Outpatier		4 🗆 IABISING L	lome 5 ☐ Reside			1)
	ng fter inel	ion;	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe ho	ow injury occurr	bed	
ISION	death death ctor: / the f	ertification;	2 Accident investigation 3 Suicide 6 Could not b	e 29a Blace of Injury At he	me farm str		Yes 2 □ No	28f. Location (St.	reet and Numbe	ar or Rum	I Boute Number
<u> </u>	pital or Attending Fours after death. eral Director: After filled in by the funer.	ertii	4 Homicide determined	building, etc. (Specify	()	cer, ractory, ornoe		City or Town		31 01 11010	THOUSE NUMBER,
	pspits hours ineral y filler	aic	29a. Certifier 178 Certifying Ph	ysician: To the best of my know	wledge, deat	n occurred at the tir	ne, date and place	e, and due to the ca	ause(s) and ma	nner as st	ated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	(Check only 2 Medical Exar	niner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my o	pinion, death occu	irred at the time, da	ate and place, a	ind due to	the cause(s)
	To To I	3	29b. Signature and title of certifier	mello m	0	29c. Licens			9d. Date signed	A	
/	20		000				41410		Juno 23)	2015.
0	2		30. Name and address of person who		- 541			MEHTY	_		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi far's Signal		RAHOM	TZ 10MM	INO	2113	3 "	
	Registr		JUN 2	7 2005	B.	foods					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State o	f Maryla		artment of <i>rtificate o</i> i				iene 9. 20	05	211	15
	Physici	an	Decedent's Name (First		*						2. Date of Deat Month	Day	Year	3. Time of	
	/Medic	al	WILLIE R		REEN			45 0% T	!	ing of Dooth	06.18			5:45	A _M
	Examin	er		ARE	HOME	MOOD	to a bight of A	4b. City, Town, BALTIC If Under 1 Yea	MORI	/	C. Data of Birds	4c. Cour	nty of Death		
	Funeral Director		5. Social Security Number 213.09 (893	_	Sex 1⊠M 2□F	7. Age (in yr	s. last birthday) Yrs.	Months Day			8. Date of Birth (Month, Day, 12 · 13 ·	Year) 1917	9. Birth	place (State of	or Foreign
	and		Usual Residence of Deced	ent County		10c. (City, Town or Lo	cation					1	0d. Inside C	ity Limits
	the Marylar 28e-f show	tor	mp	N	A	BA	LTIMOR	E						1 X Yes	2 🗆 No
	or 28e	irec	10e. Street and Number					10f. Zip Code			1		of What Cour	ntry?	
	s 23a	ral	3021 BRIGI	MON	1		110	2121		0:::-0/0:-			USA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, in a Madical Examinar must be molified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 3 ☑ Widowed 4 □ D		12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2 万 8No ve	1	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 💆 N	ban, Me	cican, Puerto I	Rican, etc.)	В	lace - Americ lack, White, cify: BLA	etc.	
215-0036	72 hour		15. D	cedent's	Education	4(65.	16a. Dece	dent's Usual Occ	upation				Business/In		
215	within 7 ene. than 'n	Completed	(Specify onf)		rade completed) College (kind of work don DO NOT use retii	e auring ed)	most of workii		OCAU	STEE		
d 21	illed w Hygier ther th		8 TH GRAD 17. Father's Name (First, I		N F	1	LAB	ORER	18. N	lother's Name	(First, Middle, I		_	<u> </u>	
Maryland	wid be i Mental I wrked o	To Be	/	EN						SIE VI					
Mar	12 sho h and 7 is ma trauma		19a. Informant's Name/Re DOROTHY R					ng Address (Stre			BALTO	-		_	
ďΣ	os 1 and 2 of Health of item 27 is rother tra		20a. Method of Disposition		100014	206	. Place of Dispo						21229 n - City or To		
e E	Pages nent o ant: if i		1 🗗 Burial 2 □ Crer `4 □ Donation 5 □ C			State	RBUTUS		ace)	06.23	· 05	BALTO.	MD		
Baltimore,	permit. Pages Department of h Important: If its any injury or of		21. Signature of Funerary	ervice Lic	ensee H		VA 51	Name and Add	ress of F	ACILITY FU	NERAL S	ERVICE MO 21	229		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Appropriate the mode of dying, such as cardiac or respiratory arrest, intensional content of the mode of dying, such as cardiac or respiratory arrest, one cause on each line.											Approximat Interval Bet	tween
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	/Medical Examiner		1650tting in death,	ſ	Due to	(or as a cons	equence of):	Heen	1	nline	· L				
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687		edical			d		700,00	VV C				4		-	
Вох	death certific e attending p od for use as t	an/M	IF FEMALE: 23b. Was decedent pregr in the past 12 month	ant	23c. If yes, ou 1□Live t	tcome of preg		Ectopic pregnar	су				Date of delive	*	Year
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ords	w require been sig should b	led b									1 □ Y€	s 2 No	3 🗌 Prob	ably 4 📑	Unknown
of Vital Records,	- 0 70	Completed									24a. Was a autops perform	241	o. Were auto prior to co death?	psy findings mpletion of c	available ause of
al F	ician: The law certificate has ector, page 2 s		05 W								1 ☐ Yes 2	No	1 Yes	2 No	
× ×	99	To Be	25. Was case referred to examiner? 1 Yes 2 No	nedicai	Hospital:	Inpatient 2	☐ ER/Outpatier	it 3□ DOA			(Check only on ne 5 ☐ Reside		other (Specif	v)	
10	ding Phys th. After this funeral di		27. Manner of Death	Pending	28a. Date (Mon	of Injury th, Day Year)					28d. Describe ho				
Division	Attending Isr death. ector: After by the funer	icatl	2 Accident	investigati Could not	be an Bloom	of laium. At	hama farm at		Yes		28f Location (St	mot and Num	mbor or Pur	J Doube Alum	abor
Div	after after Direct Direct din by	Certification;	4 🗆 Homicide	determine	build	ing, etc. (Spe	cify)	eet, factory, offic	В	-	28f. Location (St. City or Town	, State)	ilber or mura	II NOULO IVUIT	iber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 9 C (Check only 2 N	ertifying I edical Ex	Physician: To the aminer: On the b	best of my k asis of exami ner stated.	nowledge, deat nation and/or in	n occurred at the vestigation, in my	time, dat opinion,	e and place, a death occurre	and due to the ca	use(s) and ate and place	manner as s e, and due to	tated. the cause(s	3)
	To the within To the Comple	Me	29b. Signature and title of	certifier	. Q		.2	29c. Lice			2:		ned (Month,		
	d) (0	CII	SW-		m1)			164		6/2	2010	2	
1)		30. Name and address of SHOA(13	A.	1110.1	se of death (It	em 23a) (Type,	Print) Print)	TAV	3 St	Sinte :	308	Ball	mn	mp 21
	Sta Registi		31. Date filed (Month, Day	Year) 2 7 2	005	Pegistrar's Sig	nature &	and .							

			1 - For Amend Item 1	State of Ma 12 per fh G	aryland / Dep 844 6-27-0 Ce	artment of H 5 tas rtificate of I	lealth and N Death	Mental Hygi ™	ene g. No. 2 A (75 21116
			1. Decedent's Name (First, Middle, L					2. Date of Death		5. Time of Death O
	Physic /Medi		GEORGE	H.	GREENST	EIN		Month	2	Year 2005 0/35 4 M
	Exami		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death		4c. County o	
			NORTHWEST	HOSP TA	ن	RAND	ALLSTON	~	BA	LTIMORE
	Funeral Director		5. Social Security Number 6. 213-12-6681	Sex 7. Age	(In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 06/04/192		Birthplace (State or Foreign Country) MD
	pu ,		Usual Residence of Decedent							
	death with the Maryland ms 23a or 28a-f show	<u>.</u>	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	Ba-f	Director	MD BALTIM	ORE	BALTIMO	RE				1 ☐ Yes 2 ☐ No
	or 2	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	hat Country?
	ath v	ral	725 MT. WILSON			21208				U.S.A.
5-0036	hours after de ural', or Itams	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 XYes 2X N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. WHITE
5-0	72 hc	ted	15. Decedent's l (Specify only highest g	Education	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Bus	iness/Industry
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	off H	Вес	17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle, Ma	aiden Sumame,)
Maryland	should by and Menta	20	ABRAHAM		GREE	NSTEIN	DORA			KALICHMAN
ar	s 1 and 2 should f Health and Mer itam 27 Is marks other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Run	al Route Number,	City or Town, S.	
	and 2 alth 27 l		VERA GREENSTEIN	N / WIFE	725	MT. WILSO	N LANE A	PT. 539-B	ALTIMOR	RE, MD 21208
ore	ges 1 au t of Hea lf itam or othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place				ity or Town, State
Ē	Pa In:		1 🗖 Burial 2 ☐ Cremation 3: 1 4 ☐ Donation 5 ☐ Other (Spec			EMORIAL P	· 1	1/2005 R	ANDALLS	STOWN, MD
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	ensee	22	. Name and Addres	s of Facility SOI	LEVINSO	N & BRO	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused	the death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	ILSVILL it,	Approximate
1	Anysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	consequenc of):	ondary	to a	einding		Interval Between Onset and Death
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	icate be executed physician and s the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events							6 desse
ó	icate be execu physician and s the burial-tra	EX	resulting in death) Last	Due to (or as a	Sudration consequence of):					J
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		led								
O. Box	that the death certific led by the attending p detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Month	
٩,	res that signed b	by PI	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	iderlying cause give	n in Part I.	23e. Did toba	cco use contrib	ute to the cause of death?
Records,	law requires that the as been signed by th 2 should be detache								2 □ No 3	Probably 4 Unknown
	The ate ha	Completed						24a. Was an autopsy performe	prid? dea	ore autopsy findings available or to completion of cause of ath? Yes 2500
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of \	Physic this c	2	1 ☐ Yes 2 ☑ No	Hospital: Minpatier	t 2 ER/Outpatien		4 Nursing Ho	ne 5 🗆 Resident	ce 6 Other	(Specify)
Division o	ling After une	ation;	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) 28b. Time of Injury	28c. Injury Work M 1 \(\sup Y	at ? ′es 2 □ No	28d. Describe how	injury occurred	
Divis	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not l 4 Homicide determined		ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number State)	or Rural Route Number,
	n 24 houn	edical	29a. Certifier Check only one) Certifying P	hysicien: To the best of miner: On the basis of and manner stat	examination and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurr	and due to the caused at the time, date	se(s) and mann and place, and	er as stated. d due to the cause(s)
	To the To the Complex complex		29b. Signature and title of certifier			29c. License	number	29d	. Date signed (/	Month, Day, Year)
	2 /		On mother	MD.		20	059736		anne.	24 2005
Í	10		30. Name and address of person who		ath (Item 23a) (Type, I		-31176		7	1,000
			DEBORALL WAT			THWE ST	HOSFITAL	5401	OLD	COURT ROAD
	Sta Registr		31. Date filed (Month, Day, Year)	7 2005 Agestra		Acort .	11-21-17	7,01	004	Low Love
				A. C. A.	The file	Contract of the second				

			For State	State of Maryland /				lental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeath	Ra 2. Date of Death	g. No 200	7. Time of Death 7
	Physici			RKLESS				06 · 19 · 2	Day Yes	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of D	
			JOSEPH RYICHIE	1		BALTIMO				
	Funeral Director		214.64.0259	7. Age (In yrs. last t	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 01-25.	Year) 9.1	Birthplace (State or Foreign Country)
	land land		Usual Residence of Decedent 10a. Slate 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Mary I-f sh	tor	MD BALTIMO	RE WIND	SOR	MILL				1 ☐ Yes 2 🔼 No
	th the	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	ath wi	rai	8012 WOODGATE	CT. # F		212			usi	
	er dez Items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
336	al', or	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	☐ Yes 2K No	Specify:		Specify: 2	BLACK
5-0036	72 hours after death with the Maryland natural', or Items 23s or 28s-f show ites! Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation 16	ia. Deced	ent's Usual Occupa	ition	ing 1	6b. Kind of Busine	
2	within ene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d DO NOT use retired, EGISTRA)		MEDICAL	OC VICO
d 21	filed withi Hygiene. other than		12 TH GRADE 17. Father's Name (First, Middle, Last)	NA	ח	EUISTRA	18. Mother's Name			CENTER
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygene. If item 27 is marked other than "naturat", or items 23s or 28s-1 show or other traumatic event, the Modical Examinating must be notified at	To Be	RICHARD MCDOWE	iL.				VIRGIL		
ary	2 shou and M Is mar	-	19a. Informant's Name/Relationship (Ty		9b. Mailin	g Address (Street a			City or Town, State	e, Zip Code)
	1 and 2 Health tem 27 I		INGRID MCDOWEL		204	FAIRVIEW	I AVE!		MD 212	46
ore	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ F	temoval from State	tery, crem	sition (Name of natory or other place			0c. Location - City	
Baltimore,	Par Jack		4 □ Donation 5 □ Other (Specify)21. Signatule of Funeral Service License	•		DUNT			BALTO. MI	0
Ba	permit. Departr Importa any inji	SIST WHILD PIKE.								29
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or head talure. List only one cause on each line.								or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician (Medical		Immediate Cause (Final disease or condition resulting in death)	Concer of h	ely	ng with	bone me	lestaxi		3 months
	/Medical Examiner		1	Due to (or as a consequence	e of):					
		ē	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequenc	e of):					1
	cuted nd ransit	Examin	that initiated events	.						
90,	flicate be executed g physician and is the burial-transit		resulting in death) Last	Due to (or as a consequenc	e of):					
68760,	icate t physic	edicai		d						
Вох 6	:= D. 6		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d. Date of	delivery
œ.	0 0	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	res that the de signed by the a be detached f	Phys	9 Unknown					Î an muni		
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions con	between media		iderlying cause give	in in Part I.			to the cause of death? Probably 4 ØUnknown
Ö	w require been signature	etec						24a. Was an		
Rec	0 5 0	Completed by	_	perfension				autopsy perform	prior death	autopsy findings available to completion of cause of ?
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical	PYE35: 45			26. Place of Death	1 Yes 2		es 2□No
f V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	fospital: 1 Inpatient 2 ER/0	Outpatien	t 3□ DOA Othe			nce 6 Dother (S	pecify) 1-0:3
0	ding Physician: h. After this certific funeral director,		27. Manner of Dealh 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	. Time of Injury	28c. Injury Work	at ?	28d. Describe hov		
Sio	Hendi Jeath. tor: A	icatl	2 Accident investigation 3 Suicide 6 Could not be	29a Diago of Jajuan Al home	form at-		'es 2 □ No	29f Location /Ctr	oot and Number or	Rural Route Number,
Division of Vital Records,	after din by	Certification;	4 Homicide determined	28e. Place of Injury - Al home, building, etc. (Specify)	rarm, stre	eet, factory, office		City or Town,	State)	nurai noute ivumber,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	edical C	(Check only 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination a	ge, death	occurred at the tim	e, date and place, inion, death occurr	and due to the cau	use(s) and manner te and place, and c	as stated. due to the cause(s)
	thin 2 the control of	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License			d. Date signed (Mo	
	F 3 F 8		Doye B Fine 1	7' D.			02175		6-19-05	•
i	V		30. Name and address of person who co	empleted cause of death (Item 23a	a) (Type, I	Print)				
1	U		Rolfe B. Finn	. 8824 Wind	inds	Road.	Randallsto	wn, HD	21133	
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Signature	500	els.				

Amend Type or Pript in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 06 23 05 Gladys Hazel Hoyes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 105eda le der 1 Year | If Under 24 Hrs. Franklin Square HUSPITAL Center If Under 1 Year 8. Date of Birth (Month, Dey, Year) Aug. 23, 1919 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1 ☐ M 2 🖾 F Pennsylvania 216-24-3068 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show rthan "natural", or Items 23a or 28a-f shov the Medical Examiner must be twittlied at 1 ☐ Yes 2 No PARKVILLE Dundalk Directo Baltimore Maryland 21234 8810 Walther Blvd. 10g. Citizen of What Country? 10e. Street and Number Apt. 10f. Zip Code 2114 -21222United States 2545 Liberty Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens important: If item 27 Is marked other that any injury or other traumatic event, I'le once. Apartment Manager Apartments 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laura Morrison Robert G. Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carbondale, PA 18407 Box 1120 (Niece) RR 1 Jean Branco 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12℃Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 6/27/2005 Baltimore, Maryland 4 Donation ☐ @ther (Specify) Service Inc. nsee 21. Signatury of Fur 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland Ave. Part 1. Enter the disease, or complications that caused the of shock, or heart failure. List only one cause on each line. n. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part1. Onset and Death testival Immediate Cause (Final disease or condition resulting in death) Hemorrhage **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use coptribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 ☐ Yes 212 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [Inpatient 1 Yes 2 **D**No 2 ER/Outpatient 3□ DOA his 28a. Date of Injury (Month, Day Year) Director: After this in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural Injury 5 Pending investigation 1 TYes 2 No death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier Simpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who alartaga 31. Date filed (Month, Day, Year) Registrar's Signature State 7 2005 Registrar

			For State	State of Maryland	/ Department of Hea		giene
			Registrar 1. Decedent's Name (First, Middle, L.	ast) ·	Certificate of De	2. Date of Dea	Reg. No 2005 2 Time of Death
	Physic /Medi	cal	Baybaya 4a. Facility Name (If not institution, gi	Haskins	4b. City-Town, or Log	June	Day Year 2 4:45 M
	Examir	ner	Northwest	Hospital Ce	nfeit Kand	lalistown	Baltimore
	Funeral Director			Sex 7. Age (In yrs. las		Under 24 Hrs. 8. Date of Birth (Month, Day	
	72 hours after death with the Maryland insture!; or Items 23e or 28a-f show dical Examination notified at	ctor	10a. State 10b. County	note Gu	Town or Location MNN OAK		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3e or 28	of Director	10e. Street and Number Q 2 4 2 MER	RYVIEW DRIV	10f. Zip Code	1/	10g. Citizen of What Country?
	r deat	Funeral	11. Marital Status	22. Was Decedent Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, M	unic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	ours afte rrel', or It	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		pecify:	Specify: BlACK
21215-(within ane. then "	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done durin DO NOT use retired)	ng mast of working ELEASE	16b. Kind of Business/Industry State of Mola
and	should be filed ind Mental Hygid marked other umatic svent, II	To Be (17. Father's Name (First, Middle, Las	COLE	18.	Mother's Name (First, Middle,)	Maiden Sumame) Rown
, Mary	1 and 2 sho Health and em 27 le ma		BRUCE F. H	Askins	19b. Mailing Address (Street and 1	Number of Rural Route Number	r, City or Town, State, Zip Code) DAHO, Md. 21207
nore	Pages 1 nent of Hu int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci	Removal from State	ce of Disposition (Name of tetery, crematory or other place)	Dafe	20c. Location - City or Town, State
Baltimor	permit. Pag Department important: I eny injury o once.		21. Signature of Funeral Service Cice		22 Name and Address of	5 Granding July	meral de PA
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the death.	Do not enter the mode of dying, su	uch as cardiac or respiratory arr	est, Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	aenyaraH	.UM	G. Isot and Badi.
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequer	natremia		
	be executed sicien and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Valoci	omyolysis		
8760,	ate hy			d. Ventricu	lar arrh	ythmia	
.O. Box 6	The law requires that the death certific tie has been signed by the attending pi age 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnanc; 1□Live birth 2□Fetal de 4□Pregnant at time of deat 9□Unknown	eath 3 Ectopic pregnancy	V	23d. Date of delivery Month Day Year
rds, P	quires that on signed build be deta	by	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause given in		pacco use contribute to the cause of death?
Vital Records,	The law requir ate has been si page 2 should	Completed	ceveloral	vascular o	accident	24a. Was ar autops perforn	v prior to completion of cause of
/ital		Be Co	25. Was case referred to medical examiner?		26.		2 No 1 □ Yes 2 No
ō	Phys this al dii	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury 28		Nursing Home 5 Reside	ence 6 Other (Specify)
Division	Attending F r death. ector: After by the funer	catlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	(Month, Day Year)	Injury Work? M 1 ☐ Yes		
Divi	To the Hospitet or Attend within 24 hours after death To the Funerel Director: completely filled in by the f	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town	
	he Hosp n 24 hou he Fune bletely fil	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my knowle niner: On the basis of examination and manner stated.	dge, death occurred at the time, da a and/or investigation, in my opinion	ate and place, and due to the ca n, death occurred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
1	To the I within 2: To the I	Σ	29b. Signature and title of certifie	Com Mercolina	29c. License nun		9d. Pate signed (Month, Day, Year)
7	10		30. Name and address of person who	completed cause of death (Item 23	Ba) (Type, Print)	52760	JUNE 24,2005
	Sta	te	31. Date filed (Month, Day, Year)	OUV+ COO 32 Pègistrar's Signature	Ravdalltor	UN, MVyll	TOPIN NUMBER
4	Registr	ar	JUN 2 7 20	105 January Jo.	Parent	LKI(1)	TOBIN MUY)ROW,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Vear H CLUVYJUK 4b. City, Town, or Location of Death 12:300 Seloves ZL 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE If Under 1 Year If Under 24 Hrs. BALTIMORE Age (In yrs. last birthday) senesis och Date of Birth (Month, Day, Year) 6-23-2 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Days 1 □ M 2 X F Hours 216-16-08 MARYL Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE PARKUI MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 9012 tord 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□Yes 21 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) elen Lunknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/23U 19a. Info ant's Name/Relationship (Type, Print) ACT MC MC 20c. Location - City or Town, State 1012 Old Han 20b. Place of Disposition (Name of cemetery, crematory or other elace) 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 16-24-05 uneral Chapel-22. Name and Address of Facility BACTI MORE, MD 21234 21. Signature of Funeral Service Licensee EVANS FUNERALCHAPEL, 8800 HARFORD RD Molle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) brovalcular sibrillation Frich. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Heart Elizare nemic Due to (or as a consequence of):

Physician /Medical Examiner

Examiner

by Physician/Medicai

Completed

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Certification:

Medical

State

Registrar

IF FEMALE:

Physician

/Medical

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Director

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Hygiene.

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Pages 1 and 2 should nent of Health and Mer

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Completed

Be

the Maryland

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physician ar s the burial-t After within 24 hours after dearn.

To the Funerel Director: Af

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4 Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performe 2 No 26. Place of Death (Check only one)

1 Balfinore, MN 21214

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Ziaz

3 Suicide

29a. Certifier

4 Homicide

WL

29c. License number

29d. Date signed (Month, Day, Year)

MIYZa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 2 7 2005

32. Registrar's Signature Beach

TVAN JOHNSON
Baltimore, Maryland 21215-0036

				State of Maryland / Depa			•	•	
			1 - For State Registrar	Cer	tificate of	Death	Reg. I	No.	
	Physici /Medio		1. Decedent's Name (First, Middle, Last IVAN JOHNSON)		-	2. Date of Death Month	2005	3.55 AM
	Examir			RIVE	BALTIM			4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Se 816 · 34 · 3515 Usual Residence of Decedent	x The second of the second of	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Yea 05 · 31 · 19	9. Birth	nplace (State or Foreign untry)
	aryland ehow	<u>-</u>	10a. State 10b. County	10c. City, Town or Loc	_		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits 1 Yes 2 No
	he M	Director	MD NA	BALTIMOR	7		10.	0.00	
	th with t 23a or 2 1st be n		2917 ELLICOTI DE	RIVE	10f. Zip Code	ما	10g.	Citizen of What Co USA	untry?
36	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f ehow ra Madical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 🕰 Married 3 □ Widowed 4 □ Divorced	1 X Yes 2 □ No	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 🖺 No	fispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK	
Maryland 21215-0036	72 hou nature lical E	ted	15. Decedent's Edu (Specify only highest grad	ication 16a, Deced	lent's Usual Occup	pation	16b.	. Kind of Business/l	
121	d within 72 ho jiene. r than *natui r e Madical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ROOFER	during most of working d)	1	ME IMF	ROVEMENT
9	filled Hygi ther ont.		17. Father's Name (First, Middle, Last)	NA	TOULK	18. Mother's Name			MYLIVIEIGI
lan		To Be	CHARLES JOHNSO	N		RUTH HA	ILL	,	
lary	and and sm		19a. Informant's Name/Relationship (T)	7	g Address (Street	and Number or Rural			
	2 = 21 -		CORINE JOHNSC		ELLCO		ALTO. M	D 21214	
Baltimore,	ot of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State 20b. Place of Disposemetery, crem	natory or other plac	· 1	3. 05 ON	Location - City or T	Town, State
Balt	permit. Page Department Important: I eny injury o		21. Signature of Funeral Service Licens		Name and Addre	NATT PIKE	JERAL SER	VICE	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death. Do not ente	er the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Metastate 1 Due to (or as a consequence of):	Zenal	Cell (arcindi	MA	Onset and Death OMON+NS
		jer		b. Due to (or as a consequence of).					
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760,	icate be executed physician and s the burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequence of):					
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О. Вох	at the death certifica by the attending phi tached for use as th	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	/		23d. Date of deir Month	very Day Year
<u>α</u>	as tha	by	Part II. Other significant conditions co	ntributing to death but not resulting in the un	nderlying cause giv	en in Part I.		o use contribute to 2 □ No 3 □ Pro	the cause of death?
Vital Records,	The law require ate has been si page 2 should t	Completed					24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
ita		Bec	25. Was case referred to medical examiner?			26. Place of Death		10 103	2
of V	Physician: this certific ral director,	은	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		4 Nuising Hom		6 □Other (Spec	ify)
ion		ation;	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injur Wor M 1 🗆	y at 28 k? Yes 2 □ No	d. Jescribe how in	jury occurred	
Division	- 00	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specily)	eet, factory, office	28	of. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	Hospitel or 24 hours afte Funerel Dir stely filled in	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							

State Registrar

person who completed cause of death (Item 23a) (Type, Print)

BALTIMONS MID

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ELNIORA KING 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA 5A A. TIMOR THORRE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 C 6. Sex **Funeral** Days Months 1□ M 2 1 F 220.12.6552 Director 05.11 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ar then "naturel", or Itams 23a or 28a-f show the Wedical Examinar must be notified at 1 Yes 2 No BALTIMORE Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENUE DUVALL 3928 USA 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: BLACK ξ 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should ba filed within 72 in and Mental Hygiene. 7 is markad othar then "ne Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC 12 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) POWELL CHARLIE GRACIE JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an FANNIE DORIS JOHNSON-PICKENS 3928 DUVALL AVE. BALTO. MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State RANDAUSTOWN KING PARK 06.25.05 MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee VAUGHAN C. GREENE FUNERAL SERVICE anghi 5151 BAUD. NATU PIKE, BAUD. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician athoroschroti disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed/2 1 ☐ Yes 2 ☐ No 1 Tyes **2**X 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 20 No 2 SER/Outpatient 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28d. Describe how injury occurred Injury at Work? After Certification: or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М To the Hospital or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu death. 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) men 5 pleted cause of death (Item 23a) (Type, Print) Name and address of person who co Lanni St. Date filed (Month, Day, Year) egistrar's Signature State JUN 2 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June **Physician** 5:00 a M John Carroll Laur /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 150 Sullivan Rd. Westminster Carroll If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth Augusth, Data Year 934 6. Sex 1 AM 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days Hours 70 Yrs 215-30-4917 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene.

See 27 is marked other than "neturel", or Iteme 23e or 28a-f show ther treumatic event, the Medical Exertitual at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 150 Sullivan Rd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ≥ ZXNo
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 M Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transit Driver M.T.A. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lou Laur Glendora Ellean ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health a Deborah Zamencki - daughter 150 Sullivan Rd. Westminster, Md. 21157 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) permit. Pages Department of Importent: If it any injury or once. Evergreen Mem. Gardens June 28,2005 Finksburg, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eckhardt Funeral Chapel P.A. Hath 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No s certificate has l irector, page 2 s autopsy 2 No 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 일 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? After Natural 5 Pending investigation after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide within 24 hours at To the Funerel D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 234) (Type, Print) . Registrar's Signature State Registrar 2005

			•	viand / Department of Health and Mental Hygiene 2005 21121.
			1 - State Registrar	Certificate of Death Reg. No. 2003 21124 2. Date of Death 3. Time of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) DOCOTHU M.	Lanzi Month Pay, 2005 4:44 P M
>	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cer	thter 4b. City, Town, or Location of Death Towson Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 M 20 F 7. Age (In	n yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Yrs. Norths Days Hours Min. (Month, Day, Year) (Country) 9. Birthplace (State or Foreign Country)
	arytand show	_	Usual Residence of Decedent 10a. State 10b. County 10c.	Oc. City, Town or Location 10d. Inside City Limits
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		Funeral Director	11. Marital Status 1 Never Married 2 Married 11. Was Decedent Ever Armed Forces? 1 Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
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Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Ligensee	22. Name and Address of Facility BALTING RE, MD 21234. EVANS FUNERAL CHAPEL 8800 HARFORD CD.
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)	14		30. Name and address of person who completed cause of deat	DØØ57593 June 24, 2005
1	り		ALEXANDER SANG NA. M.D.	. 7601 OSLER DRIVE TOWSON, MARYLAND 21204
	St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Sejistrar's	s Signature

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П	Physici	30	1. Decedent's Name (First, Middle, Last) A				2. Date of Dea	Day Ye	3. Tirne of Death
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Division	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, ify)	factory, office		28f. Location (5 City or Tox		r Rural Route Number,
_	Hospitel or Attending 14 hours after death. Funeral Director: Afte tely filled in by the fune		29a. Certifier 1	Certifying Phy	ysician: To the best of my kr	owledge, death oc	curred at the tin	ne, date and place	and due to the	cause(s) and manne	or as stated.
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			30 Name and add	est person who	completed cause of death (Ite	em 23a) (Tuna Prin	1400	6/180 more, M		June	9, 2005
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	arylan	-	artment of H <i>rtificate of L</i>		ind Menta	l Hygien Reg. N			
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	with the	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?		
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<u>,</u>	The law requires that the site has been signed by the bage 2 should be deteched.	by	Part II. Other significant conditions Acute Reval Failu		ut not resi	ulting in the u	nderlying cause give	en in Part I.	236	_		the cause of death?	
Hecords	w require been sig should t	eted	Acute Reval Failu	CC						1∐Yes a —————— Wasan		bably 4 Unknown	
al He		Completed							10	autopsy performed? Yes 2 N	death?	opsy findings available ompletion of cause of	
Vital	Phyeician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 25. No	Hospital:	nt 2 🗆	ER/Outpatier	nt 3 DOA Othe		of Death (Check		6 ☐ Other (Spec	u(tv)	
27. Manner of Death 28a. Date of Injury 28b. Tim						28b. Time o Injury	f 28c. Injury Work	at	28d. Des	scribe how inju			
						ome, farm, str	reet, factory, office			ation (Street a or Town, Sta	and Number or Ru te)	ral Route Number,	
	e Hospita 24 hours e Funera letely fille	edical C	29a. Certifier (Check only one) Check only 2 Medicel Expenses	Physician: To the best aminer: On the basis of and manner sta	examina	wledge, death tion and/or in	h occurred at the tim vestigation, in my op	ne, date and pinion, deat	d place, and due h occurred at the	to the cause(time, date ar	s) and manner as nd place, and due	stated. to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier				29c. License				ate signed (Month		
	۸.		~~	M.D.			RES - C	300		June 22, 2005			
	4		30. Name and address of person with David Majure Johns Hop			, , , , ,	*	e km	hall in Kin	Des de 6	2. 4 M	1 21287	
	Sta		31. Date filed (Month, Day, Year)	32. Pegistra	ar's Signa	iture	1015 Hours	- 000	OF IN WATE	JII CCI P	KUMORE MI	S LILUT.	
	Registr	ar	JUN 2 7	ZUUS Meser	0	J. A.	rave						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 **Physician** June 24 2:35 P.M Joseph Mento, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1505 Neighbors Avenue Baltimore Rosedale 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 6, 1926 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 ☐ F Months Days Hours Min 78 Yrs. Maryland Director 217-20-2879 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Rosedale Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1505 Neighbors Avenue 21237 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Itel 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White by 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 yr's Cafeteria Manager Maryland Cup 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Η. Mento Agatha Pollicino Joseph ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Concetta M. Mento - wife 1505 Neighbors Avenue Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD 6/28/05 4 □Donation 5 MOther (Specify) entombment Baltimore, MD 22. Name and Address of Facility 21. Sign vure / f Funeral Service Licenses 5305 Harford Rd. Baltimore, MD Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage Physician disease or condition resulting in death) ongestive /Medical Due to (or as a consequence of): **Examiner** pertension Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? res 2 No 130 mm 1 ☐ Yes Division of Vital oronary To the Hospital or Attending Physician: 25. as case referred to medi-examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 9 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural Accident 5 Pending investigation death. within 24 hours after death To the Funeral Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) MB D3506 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3100 wyman Park De , m)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar

2005

68760,
Вох
P.O.
Records,
Vital
of
Division

			Please T	ype or Print in B				-		
			1 - For State Registrar	State of Maryland		artment of F rtificate of			giene 2005	21128
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Year	3. Time of Death
	/Media		Sarkis Martirosian					6	21 2000	
	Examir	er	4a. Facility Name (If not institution, give s	treet and number) ARE HOSDITA	1/	4b. City, Town, o	or Location of Death	1	4c. County of Dea	th HORE
7	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	4	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign
	Director		230 83 2340 Usual Residence of Decedent	^{™ 2□F} 57	Yrs.	Months Days	Hours Min.	Dec. 26,	1947	Iran
	yland		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	8e-f sl	ctor	Maryland Baltimore	e M	iddle	River				1 ☐ Yes 2 ☑ No
	with th	Dire	10e. Street and Number			10f. Zip Code	20		10g. Citizen of What C	ountry?
	eath	era	122 Compass Rd.	12. Was Decedent Ever in U.S	112	2122 Was Decedent of h		agaifu Vac as Na	USA 14. Race - Am	rices lodies
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "neturel", or Items 23e or 28e-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Black, Whi	
2-0	72 ho	ted	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	oation	king	16b. Kind of Business	/Industry
21	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	during most of word)	N'''19	Warehousi	
121	filed with Hygiene. other ther		47 Fathada Nama (Fires Middle 1 ans)	4	Walte	eriouse wo			Warehousi	19
Maryland	12 should be fi h and Mental H 7 Is marked ot treumatic ever	Be	17. Father's Name <i>(First, Middle, Last)</i> Martin Martirossia n	1				ne (First, Middle, Navasaro	Maiden Sumame) di an	
Ž	hould d Me mark matic	ို	19a. Informant's Name/Relationship (Type		10h Maili	na Address /Ctross			r, City or Town, State,	Zin Code)
Ma	ulth an 27 is i		Lois Elaine Durm (F		1	-	d. Baltir			zip code)
ē,	permit. Pages 1 and i Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition	20b. Pl	ace of Dispo	osition (Name of matory or other pla	cal	Date	20c. Location - City or	Town, State
E	Page nent o int: If		1 ∑Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emovariiom state			rdens 6/2	5/2005	Baltimore,	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License		2:	2. Name and Addre				. Idi j zdra
8	89 = 9		John W. Be	vekouske	1	1407 Old	Eastern A	Avenue Es	ssex. Md. 2	21221
	Physician		23a. Pa/t1. Enter the disease, or compli- stock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death the cause on each line.	. Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequ	ence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					
	e be executed sician and e burial-transit	Examiner	that initiated events							
,09	be executed ician and burial-transi		resulting in death) Last	Due to (or as a consequ	ence of):					
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x 68	that the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE:	3c. If yes, outcome of pregnar	201/			70.00	1	
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	The law requires that the tte has been signed by the bage 2 should be detache		Part II. Other significant conditions con	tributing to death but not resu	lting in the u	inderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	the cause of death?
rds	w requires that been signed k should be det	ed k	CHF					1 □ Y	es 2□No 3□P	robably 4 Unknown
Division of Vital Records,	faw re as be 2 sho	Completed by						24a. Was a		utopsy findings available completion of cause of
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/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?			0.1		th (Check only or		
of	Physical this call dir	10	1 ☐ Yes 250 No	1	ER/Outpatier	IL 3 DOA			ence 6 Other (Spe	cify)
UQ	ding h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No	28d. Describe in	ow injury occurred	
/isi	Attending r death. sctor: After by the funer	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	me, farm, st			28f. Location (S	treet and Number or R	ural Route Number,
Ö	s after s after bl Dire	Certification;	4 Homicide	building, etc. (Specify,)	,		City or Tow	n, State)	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Madical Examin	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens	se number	11 2	29d. Date signed (Mon	h, Day, Year)
	201) (. / /yw	10		100	0510	17 1	June 2	1 2005
	1) 4		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	0 1-		, 1	
6			DR ERIC NAGER 31. Date filed (Month Day Year) JUN 2 7 2005	9000 FRAUK II.	N Se	WARE D.	R. BAIT	more,	Md 21:	237
	Sta Regist		JUN 2 7 2005	Elever &	Sport	all!				

			for State	State of M	laryland / De	partmer <i>ertificat</i>			nd M				
			Registrar 1. Decedent's Name (First, Middle, La	et)		eruncai	e or i	Deam		2. Date of Dea	Reg. NO	0.5 -	21129
	Physici	an								Month	Day	Year	
	/Medic		William 4a. Facility Name (If not institution, given	E .	Phillip		Tour	- 1tion of	(Decale	June 24			12:55 pm
	Examir	er						r Location of	Death			y of Death	
			Gilchrist Center : 5. Social Security Number 6. S		e (In yrs. last birthda	If Unde	SON r 1 Year	If Under 2	4 Hrs.	8. Date of Birt	Balti	1	
	Funeral Director			X M 2□F	68 Yrs.	Months		Hours	Min.	May 14,	y, _{Year)} 1937	Pen	^{place} (State or Foreign ntry) nsylvania
	land		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
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	the 286	Director	Maryland Baltimor	re	Essex	10f. Zip	Code				10g. Citizen of	What Cou	intry?
	3a o		96 Ginwood Lane			21	221				II C	7\	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent		3. Was Dece	dent of H	lispanic Orig	jin? (Sp	ecity Yes or No-	U. S.		ican Indian,
ယ	after or Ite	큔	1 ☐ Never Married 2 Married	Amed Forces		_	191	an, Mexican,	Puerto	Rican, etc.)	Bla	ick, White	, etc.
Š	rel', c	ð	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	21 X No	Specify:			Speci	fy: W	hite
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	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28e-1 show sumatic event, the Medical Exertires must be rediffed at	ပ္ပိ	12		Age	ent							Company
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<u>\$</u>	should ind Men ind marke	2	William W.	Phillips				Rose		Druzg			
Maryland	2 sh and Is m	1 3	19a. Informant's Name/Relationship (al Route Numbe			•
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan aritment of Health and Mental Hygiene. ortent: If item 27 Is marked other then "naturel", or Items 23a or 28e-1 show injury or other traumatic event, the Medical Examinating must be notified at injury or other traumatic event, the Medical Examinating number of 116e at		Thomas Druzgal (Co	ousin)	20b. Place of Dis			s Driv		Fayette			
Baltimore,	Pages nent of H ant: If ite		1 🔀 Burial 2 ☐ Cremation 3 ☐		cemetery, c	rematory or c	other plac	16/	/30/	2005	20c. Location	- City or i	own, State
Ħ	permit. Pages Department of Importent: If i any injury or o		`4 □Donation 5 □Other (Specia		Holly H					s	Baltin	nore,	Maryland
Ba	permit. Departn Importe any inju		21. Signature of Funeral Service Lice	6 11		Bruzdz	insk	ss of Facility i Fune	eral	Home P		25	2 27000
	Sec. Lab		23a Part 1 Enter the disease or and	office.		1407 O						lary L	and 21221 Approximate
			23a. Part1. Enter the disease, or shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ine.	sinter the mod	or dylli	ig, such as c	ardiac	or respiratory ar	1651,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	V9 Car	1005							Montas
	Examiner			Due to (or as	a consequence of):								
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Ć,	cate be executed physician and the burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequence of):								
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9		ledi											
Вох	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pi					23d. Da	ate of deliv	ery
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			5 ☐ Other (s _t					Me	onth	Day Year
P.0	that the de ed by the a detached t	h	9 Unknown										
Ś	es tha igned be de	by f	Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying o	ause givi	en in Part I.				tribute to t	he cause of death?
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<u> </u>		Con								perfor	med?	death?	
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of	Physician: this certific ral director,	Jo	1 ☐ Yes 2 DNo	Hospital: 1 ☐ Inpati				4 Nuis		me 5 Resid	- 10	ner (Specii	nhospice
		lon:	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time uy Year) Injun	/	8c. Injun Work	k?		28d. Describe h	ow injury occur	rred	
Sic	r Attending er death. rector: After by the fune	cat	2 Accident investigatio 3 Suicide 6 Could not b	A		М	-	Yes 2□N	_				
Division	2 9 5 6	Certification:	4 Homicide determined	building, e	jury - At home, farm, tc. (Specify)	street, factor	/, office			City or Tow	n, State)	ber or Rura	al Route Number,
_	spita lours nerel		29a. Certifier Certifying Pt	ysician: To the best	of my knowledge, de	ath occurred	at the tim	ne, date and	olace.	and due to the o	ause(s) and m	anner as s	tated
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner si	of examination and/or	investigation	, in my or	pinion, death	occurr	ed at the time, o	date and place,	and due to	o the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	0		290	. License	e number		2	29d. Date signe	ed (Month,	Day, Year)
	-/:		1 Al la	Mus			1)5	330	3		Ens	24	2005
	104		30. Name and address of person who		death (Item 23a) (Typ	e, Print)							
	10		DARON CHARI	Es uno 66	501 N. C	Marle	0 85	Balt	mon	c 1102	1204		

State Registrar

DHMH 17 Rev 1/2001

JUNE 24, 2005

WILLIAM

			For State Registrar	State of M	larylan	d / Depa		t of H	ealth an	d Mental I	Hygiene	-		21130
	Physici	an	1. Decedent's Name (First, Middle,							2. Date o Month	Da	у Ү	ear	3. Time of Death
	/Medic		JERRY	Ross			1			JUN		20	05	3:40 PM
	Examin	er	4a. Fecility Name (If not institution, g	AT 19205					Location of D		4c	. County of	Death 1tim	070
	F					last birthday)	If Under		If Under 24		f Birth			ce (State or Foreign
	Funeral Director		217-60-3504 Usual Residence of Decedent	1 X M 2□F	59	Yrs.	Months	Days		Ain (Month	Day, Year) 1946		Countr	inia
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	d. Inside City Limits
	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or flems 23a or 28a-f show event, the Medical Erapinal must be notified at	Funeral Director	MD Balti	more		Reis	terst							1 ☐ Yes 2 🛣 No
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	ns 23	erai	743 Main	12. Was Deceden	t Ever in U	.S. 13.1	Was Deced	tent of Hi	21136		r No-	U.S 14. Race -		n Indian
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8	ral', o	by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1□ Yes	2 X No	Specify:			Specify:	W	hite
Maryland 21215-0036	c . M	Completed	15. Decedent's (Specify only highest	grade completed)	- 1	16a. Deced (Give	dent's Usua kind of wor DO NOT us	rk done d	uring most of	working	16b. K	ind of Busin	ness/Indu	istry
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Nar	S 8 8		19a. Informant's Name/Relationship			1				r Rural Route No			ate, Zip C	Code)
	of Health item 27 other tr		Loretta Howard 20a. Method of Disposition	Sister	20b. F	P.O.				rstown,		:1136 ocation - Cit	hr or Tow	n State
Baltimore,			1 ☐ Burial 2 🗓 Cremation 3		9	Place of Dispo cemetery, crer			1					
Ħ	2 2 2 2		 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice 		Ca	rroll (6/24/05 11824 R		mpste		
Ba	Departmine Department on it		Stephen	-m Ja	uki	,				me Reis				1136
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8760,	Examiner	cai Examiner	Sequentially list conditions, if any, leading to infilted attacts cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	b. Due to (or a c. Due to (or a d.	peenue s e	venes of).								
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Division	il or Attending after death. Dirsctor: After d in by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of I	njury - At he etc. (Specif	ome, farm, str y)	eet, factory			28f. Location City or	on (Street ar Town, State	d Number (or Rural I	Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C	29a. Cartifier (Check only one) Certifying 2 Medical Ex	Physician: To the best taminer: On the basis and manner s	of examina	owledge, death	h occurred vestigation,	at the tim , in my op	e, date and pl inion, death o	lace, and due to	the cause(s me, date and	and manne d place, and	er as stat I due to t	ed. he cause(s)
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	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 7 2		trar's Signa	H. Go	ale							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 2005 Stella R. Self 7:10PM 23 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richie Hospice Bartimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 3-17-1936 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 261-56-4209 1□M **X**□F 69 Yrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD Baltimore Director 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code U.S.A. 1101 Pennsylvania Ave. 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Eventernones. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Health Care Home Health Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susie Jackson unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Hodge (daughter) 1115 Argyle Ave. Baltimore MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Druidridge Cem. 30June2005 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Funeral Service 1300 Eutaw PL. Baltimore MD 21. Signature of Funeral Service Licensee E.N. Walker Jr. 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acquired Immunode ficiency **Fnysician** disease or condition resulting in death) 4205 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, any leading to min educa-cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent oregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Breast cancer Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Nother (Specify) HOS ICE 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide thin 24 hours a tha Funeral D 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29b. Signature and title of certifier 5 6 29c. License number 29d. Date signed (Month, Day, Year, MO 6-23-2005 DS1788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 620 Boulton Street Bel Air ND 21014 POIK MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 7 2005 Registrar Blan & Spark

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Satterfield Teresa J. JUNE 23, 2005 1:22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson Hours Min. 8. Date of Birth (Month, Day, Year) March 26,1926 5. Social Security Number If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Days 79 Yrs. 219-18-1520 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Co. Parkville 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3107 Edgewood Avenue 21234 United States or Items 23c Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and teem 23 is marked other than "natural", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary Catholic Center 10 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johanna Moeller John Adam Schreiber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3956 Forest Valley Rd. Parkville, MD 21234 Regina E. Satterfield / Daughter 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o June 27,2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Most Holy Redeemer 21. Signature of Funeral Service 22. Name and Address of Facility 5305 Harford Road Michael E. Canapp Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filiysician disease or condition resulting in death) aRESPIRATORY FAILURE /Medical Due to (or as a consequence of) **Examiner** b.PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy jo in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an 22 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06-74-05 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 DRIVE TOWSON MARYLAND 21204 31 Dale Neu Month, Day Year) M. D. State Registrar

		-	For State Registrar	State of Maryland		rtment of H			iene .g. No 200	5 21133
	D 1		Decedent's Name (First, Middle, Last)					2. Date of Deat	th	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give st			•	Location of Death		4c. County of E	
	Funeral		Millenium Health 5. Social Security Number 6. Sex	7. Age (In yrs. las		Glen Bu	If Under 24 Hrs.	8. Date of Birth	A . A	Birthplace (State or Foreign
	Director		214.62.1368	м 2ДГ 79	Yrs.	Months Days	Hours Min.	(Month, Day, 3-26-1	Year)	Country) Philippines
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
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	with the 3a or 28a It be notif	i Direc	10e. Street and Number 1225 Crawford Driv	re		10f. Zip Code 21061		1	0g. Citizen of Wha	
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23s or 28s-f show armstic event, the Marical Examiner must be notified.	y Funeral Director	1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☐ No If Yes, Give	lf lf	Vas Decedent of Hi Yes, specify Cubal	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc. Filipino
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73	should be filed and Mental Hygis s marked other umatic svent, II	To Be C	17. Father's Name (First, Middle, Last) Emilio Paragas				18. Mother's Name Teodor	e (First, Middle, 1		
lary	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street a	and Number or Run	al Route Number	, City or Town, Sta	te, Zip Code)
₹.	1 and 2 Health tem 27 l		Lorelei Sattler, Da				Drive, Se			
Baltimore,	ages 1 a nt of Hea : If item · or othe		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □ Re	emoval from State Cro	netery, cren WNSV 👆	sition (Name of hatory or other place Lle Veter	e)		20c. Location - City	
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,			30. Name and address of person who con	moleted cause of death (terms	222) 77	D C	5,1075	5	6-2	4-05
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	dical niner	Joshua C 4a. Facility Name (If not institution, g	harles ive street and number)	Sher		or Location of Death		4c. County of Dea	
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Funer Directo			Sex 7. Ag 1∭3 M 2□F	e (In yrs. last birthda) Yrs.	Months Days		8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
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larylan show	١	10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
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ter death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13		Hispanic Origin? (Spe pan, Mexican, Puerto		S. A.	
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To the within To the comp	M	29b. Signature and title of certifier	1 -1	1	29c. Licens		ľ	d. Date signed (Monti	
		1 N	VI. JA					June, 24,	2005
		30. Name and address of rerson who	completed cause of d	eath (Item 23a) (Type	Print 111 Pen	n Street	Baltimor	e, Maryla	nd 21201
	State	31. Date filed (Month, Day, Year)	32. Sgistra	ar's Signature	1				
Regi	strar	JUN 2 7 3	2005 Sie	w Signature	0542				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SUNT 2005 /Medical 4a. Facility Name (If not institution, give street and питьег) 4c. County of Death 4b. City, Town, or Location of Death Examiner 42 ark If Under 1 Year If Under 24 Hrs. HARFORD 6.Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Months Days Hours 229-56-718 Yrs Director Usual Residence of Deceder 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avant, the Medical Examinational be notified at 1 ☐ Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 425 Completed by Funeral 12. Was Decedent Ever in U.S. Atmed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Management Anal 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be uther ဂ္ land 19a. Infor ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility ALTIMORE MD 21234. EVANS FUNERAL CHAPEL 8800 HARFARD RD 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, and one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KPIN Pnysician /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a nsequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Cther (specify) 9 Unknown à Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by funeral director, page 2 should be 3 Probably Unknown 1 Tyes 2 No RENA 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 2 No 25. Was case referred to medical examiner? 26. Pface of Death (Check only one, Other: 1 ☐ Yes Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner 28b. Time of 28d. escribe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Diractor: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide The cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie 29c. License number 06/23/05 D00036231 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N: BACTO NO 212 DI ME MO 51

Registrar

32. Registrar's Signature

JUN 2 7

2005

			1 - For Amend Registrar	Item 10	State of Mean Per	aryland fh G	844 Ce	artment rtificate	of He	ealth and Meath	lental Hy	giene Reg. NQ (005	21106
	Divisio		Decedent's Name (First								2. Date of Dea		Year	3. time of beat
	Physici /Medi		Aian	H	Sc	hm	all				June	22	2005	4:45PM
	Examir	ner	4a. Facility Name (If not it	^ .		edical	Conter	4b. City, To		ocation of Death		4c. Co	ounty of Death	-
	Funeral		5. Social Security Number	er 6. Se:	7. Ac		st birthday)	If Under 1		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v Year		place (State or Foreign
	Director		156-34-967	//	M 2 F	60	Yrs.	WORKINS	Days	TIOUIS WIII.	03/08/1		Cour	NY
	show			. County			Town or Lo						· ·	10d. Inside City Limits
	the Mar. 28a-f sh	ctor		OWARD		C0	LUMBI	4						1 Yes 2 No
	th with th	Funeral Director	10e. Street and Number Angel 9562 ANGLE	ina LINE CII	RCLE			10f. Zip C	045			10g. Citizer	U.S.A.	ntry?
5-0036	after dea	b	11. Marital Status 1 Never Married 3 Widowed 4 I		12. Was Decedent Armed Forces 1 ☐ Yes 2 M If Yes, Give Year or Dates:			Was Decede If Yes, specif	y Cuban V	panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, Decify: WH	etc.
5-0	"natural",	etec		Decedent's Edu			16a. Dece (Give	dent's Usual kind of work	Occupat done du	ion Iring most of work	ing	16b. Kind	of Business/In	dustry
2121	within ene. than "	Completed	Elementary/Secondary	y (0-12)	College (1-4or	5+)		TER SC				COMP	UTERS	
d 2	e filed at Hygi other vent, L	a	17. Father's Name (First,	, Middle, Last)						18. Mother's Name	e (First, Middle,	Maiden Su	rmame)	
ylar	should be filed withir nd Mental Hygiene. s marked other than umatic avent, the Mental than the matic avent, the Mental than the matic avent, the Mental than the matic avent, the Mental than	To B	MORTON			S	CHMAL			DOROTHY				SHAPIRO
, Maryland	and 2 sho alth and 127 is ma ar trauma		19a. Informant's Name/F		rpe, Print) IFE		19b. Maili	Ange I Ange I ANGLE	Street and	CIRCLE	·COLUMB	A, ME	own, State, Zip) 21045	Code)
Baltimore,	m C		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre 1 ☐ Donation 5 ☐	emation 3 🗆 F	temoval from State	се	metery, crei	sition (Name matory or oth ARDENS	of er place)) !) 1/2005	OLNEY	tion - City or To	own, State
Balti	permit. Page Department o Importent: If any injury or		21. Signature of Funeral		98					of Facility SOL				
	TI I		23a. Part1. Enter the dis	sease, or compl ure. List onty or	ications that cause ne cause on each I	d the death.	. Do not ent	er the mode	of dying,	, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		Cong	esti	ie +	teart	F	Failure.				Onset and Death
ı	/Medical Examiner		, , , , , , , , , , , , , , , , , , , ,	ſ	Due to (or as	a consequi	ence of):							
Ü.		ner	Sequentially list condition if any, leading to immedicate any leading to immedicate any leading to the sequence of the sequenc	iate	Due to (or la	a consequ	ence of):							
	ifficate be executed ig physiclan and as the burial-transit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as	2.00000000	ones of):	· · · · · · · · · · · · · · · · · · ·						
68760,	siclan burial				Jue to (or as	a consequi	ance or,							
	tificate ig phy as the	ledicai			J									
.O. Box	that the death certified by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1 Yes 2 No 9 Unknown	ths?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[Ectopic pred Other (spec				230	I. Date of delive Month	Day Year
۵.	Se 00	by Pt	Part II. Other significant	t conditions co	ntributing to death t	out not resul	lting in the u	nderlying cau	ise given	n in Part I.				ne cause of death?
ord											1 🗆 Y		No 3 Prob	
Il Records,	The la ate has page 2	Completed					-					an 2 sy med? 2 No	death?	psy findings available mpletion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to examiner?		lospital:				Other	26. Place of Death				
of	문 등 교	n: To	1 ☐ Yes 2 No 27. Manner of Peath		28a. Date of Inju	ıry :	R/Outpatier 28b. Time o		. Injury a	4 Nursing Ho	me 5 🗌 Resid 28d. Describe h			y)
ion		atio	2 Accident	Pending investigation	(Month, Da	ly Year)	Injury	М		es 2□No				
Division	al or Atte s after de il Directo	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Płace of In building, e	jury - At hor tc. (Specify)	ne, farm, sti	eet, factory,	office		28f. Location (S City or Tow	treet and N n, State)	lumber or Rura	l Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai (29a. Certifier (Check only ane)	Certifying Phy Medical Exami	sician: To the best ner: On the basis of and manner st	of examination	rledge, deat on and/or in	h occurred at vestigation, in	the time	, date and place, nion, death occurr	and due to the ded at the time, d	cause(s) and pla	d manner as s ace, and due to	tated. the cause(s)
	To the comp	Σ	29b. Signature and title of	of certifier	2 10			29c.	License	number	:	29d. Date s	igned (Month,	Day, Year)
	01		SUNCE	Lake	Yack	- M	D	7	18	3543		Time	22,2	200
	0		30. Name and address of 22 South		ene st	eath (Item	_	1tmo	e	MD	2120	ì		
	Sta Regist	ate rar	31. Date filed (Month, Da			ar's Signati		Assil	9					
				JUN & /	LUUJ KA	San Alasan	-	-						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 515 Bright Hold 4c. County of Deeth Examiner Conta Lutharille Baitimore Luthemile MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Deys | Hours | Min. | (Month, Day, Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2□ F 85 21709603 Baltimore, MD 8 Director Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 20 No Baltimore Timonium Funeral Director Maryland 10g. Citizen of Whet Country? 10e. Street end Numbe 10f. Zip Code filed within 72 hours after death with 21093 2124 U.S.K tineval 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc 1 Never Married 2 Merried 1 ☐ Yes 2 12 No 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 specify: White Be Completed by 3 Widowed 4 Divorced "naturel" 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiena. int: if Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Keal Self Em 010 N 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) aura -0 rac ederi CI wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Timonium, MA 21093 Mabe inevalle 212 Tracy 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of Important: if it eny injury or conce. Burial 2 Cremation 3 Removal from State June16 ulaney alley 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Funeral + Cremation Timonium, Rde 2325 Approximete Interval Between Onset and Death 23a. Part. But if the diseale, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by the next failure. List only one city e on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) ACUTE MYUCALDIAL INFARCTION MIN Examiner by Physician/Medical Examiner DHUNAKY ANT tor: After this cartificate has been signed by the attanding physician and the funaral director, page 2 should be datached for usa as the bunal-transit or Attending Physician: The law raquiras that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown TURY 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Be Completed completion of cause of deeth? Director: After this cartificate has I 2 1 No 1 ☐ Yes 2 E No 1 🗆 Yes 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 Could not be determined To the Hospital or Atterwithin 24 hours after des To the Funeral Director complataly filled in by th 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47945 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) DUIVE TOWNW UND ZIZOH MS 2505 127160

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

JUN 2 7

2005

			Please 1	Гуре or Print in Black In	idelible ink. Ensure A	I Copies Are	e Legible.
			For State Registrar	State of Maryland / Dep	artment of Health and Martificate of Death	lental Hygier	ne .
			Registrar 1. Decedent's Name (First, Middle, Last		Tillicate of Death	Rag. N 2. Date of Death	COUD Ca. time of Death
	 Physici /Medic 		TAMARA	THOMPSON		June 2	3, 2005 9:00 PM
	Examir		4a. Facility Name (If not institution, give	street and number) OF Bathmore	4b. City, Town, or Location of Death Baltimore C	it/	4c. County of Death
	Funeral		Sinai Hospital 5. Social Security Number 6. Se		If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		220-60-6710	M 2 5 /F 39 Yrs.	Months Days Hours Min.		967 Country) MD
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	e Maŋ	ctor	MD	Balto	,		1 ☑ Yes 2 ☐ No
	with th	Funeral Director	3710 OLD FreDe	erick Rd.	10f. Zip Code	10g. (Citizen of What Country?
	death	nerai	11. Marital Status		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
21215-0036	tiled within 72 hours after death with the Maryland Hyglene. ther then "natural", or Items 23s or 28e-f show int. The Medical Examinat must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Black, White, etc. Specify: BLACK
15-	in 72 h	ojete	15. Decedent's Edu (Specify only highest grad	le completed) (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry
212	be filed within 72 ho ital Hygiene. id other then "natur event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Disable		N/A
Maryland	a la la la la la la la la la la la la la	To Be (17. Father's Name (First, Middle, Last) LARRY TUNS	TALL	18. Mother's Name	(First, Middle, Maide	en Sumame) MPSOY
ary	ges 1 and 2 should be f it of Health and Mental b If Item 27 is marked of or other treumetic eve		19a. Informant's Name/Relationship (T)	ype, Print) 19b. Maili	ing Address (Street and Number or Run	Al Route Number, City	
	1 and Health em 27 ther tr	1	PAIriCIA 1HOMPSO	n - Mother 3710	OLD Freberick	Rol. BALL	OMD 21229 Location - City or Town, State
mor	Pages nent of I int: If Its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State cemetery, cre	matory or other place) RMEL CEM 6-36		34 Ha MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 ti eny injury or other tre 90028.		21. Signature of Euneral Service Licens		2. Name and Address of Facility Michael Ziglier Foun		011110.1110
	20 E 2 9		23a Part 1 Enter the disease or comp	lications that caused the death. Do not en	4.0. DOX 65338 PAIT	6.14D. 7171=	Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	1.4.	rus	Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	arough dericy vii	V13	5 years
8	LAdrinier	ē	Sequentially list conditions, if any, reading to introduce cause. Enter Underlying	b. — Cha to (or as a nonsequence of):			
	cuted nd ransit	aminer	that initiated events	c			V
60,	ficate be exec physicien an s the burial-tr	Ä	resulting in death) Last	Due to (or as a consequence of):			
68760,	ficate physics the t	edica		d			
Вох	death certificate b attending physic	an/M	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetał death 3	□Ectopic pregnancy		23d. Date of delivery
-	requires that the death certificate be exe een signed by the attending physicien ar nould be detached for use as the burial-t	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 5[9□Unknown	Other (specify)		Month Day Year
, P.O.	res that the de igned by the a be detached i	y Ph		ntributing to death but not resulting in the t		23e. Did tobacco	o use contribute to the cause of death?
ords	w require been sig should b	ted t		Distress Syndrome,	Pneumonia,	1 🗆 Yes	2 No 3 □ Probably 4 □ Unknown
Vital Records,	S S S	Completed by Physician/Medical	Kidney Failure,	Hepatitis C		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ita		Be Cc	25. Was case referred to medical		26. Place of Deatl	1 Yes 2 (Check only one)	No 1 ☐ Yes 2 No
of V	this ald	6	TE TOS ACINO	Hospital: 1 Inpatient 2 ER/Outpatie			6 ☐Other (Specify)
on	ffe on	tion	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred
Division of	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
	bours annered ly filled	alCe	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, deal	th occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	the Hohin 24 the Fu	Medical	one)	iner: On the basis of examination and/or in and manner stated.	29c. License number		
	Mit 70	-	29b. Signature and title of certifier	maran			Date signed (Month, Dey, Year) 23 2005
١			I am	ompleted cause of death (Item 23a) (Type,	, Print)		U Dijest
			EILECH ZINGME 31. Date filed (Month, Day, Year)	an DU SINAI H 32. Spistrar's Signature	ospital of Baltimo	ore	
	Sta Registi			an DO Sinai H 32. Figistrar's Signature	pset		

DHMH 17 Rev 1/2001

			State of Ma 1- State Amend Item#20b per FH (ryland / Department of Health and N 5845 7/15/05/05 Certificate of Death	Mental Hyg	iene
			Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h CUUS (3. Time of Death)
	Physicia /Medic		Horace Williams		June	19 2007 1042 9 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
	-		5. Social Security Number 6. Sex 7. Age	o (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Bartimore City 9. Birthplace (State or Foreign
	Funeral Director	,	319-50-1894 10M 20F 5	Yrs. Months Days Hours Min.	T(Month, Day,	0.1950 North Carolina
	pu »	-	Usual Residence of Decedent 10a. State 10b. County	100 City Taylor of Locality		Jan Carolina
	Aaryla I shov	ō	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits 1 XYes 2 □ No
	288-1	Directo	Marylana IV/7	101. Zip Code	1	0g. Citizen of What Country?
	h with		1641 Thomas Av	21211		11 < A
	ems 2	Funeral	11. Marital Status 12. Was Decedent 8 Armed Forces?	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 Never Married 2 Married 1 Yes 2 N	lo 1 ☐ Yes 2 █ No Specify:	5 T HOLEN, 010.7	Specify: D L
215-0036	72 hours after death with the Maryland neturel; or Items 23a or 28a-f show iteal Examiliat must be reditted at	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
215	within 72 iene. than "ne the Medic	Completed	(Specify only highest grade completed) Elementary/Sacondary (0-12) College (1-4or 5	(Give kind of work done during most of work	king	O
2	filed with Hygiene Ather thau	Com	70	Laborer		Construction
nd	be file	Be	17. Father's Name (First, Middle, Last)	- 1	ne (First, Middle, I	Maiden Sumame)
Maryland	should be and Mental marked o umetic eve	ဥ	Dennis Williams 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rui	1 91	ay Sada Zin Sada
Ma	0 0 0 0		Mrs Gloria William	1641 Thomas	Aug D	CITY OF TOWN, STATE, 21p Code)
ē,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		705 racie	Balto MA.
alti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility JOSEPH L. RUSS	Tiporal	Home PA.
	g 0 = g 0		pseph Z. Tu	11 2222 W. North Ave	Baite	Md.21216
			23a. Pafyl. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir. Immediate Cause (Final	the death. Do not enter the mode of dying, such as cardiac ne.	or respiratory arr	est, Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	<u> </u>		
	Examiner			a consequence of):		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enne Underlying Cause (Disease or injury	a consequence of):		
9	The law requires that the death certificate be executed the has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	Examiner	that initiated events			
8760,	be exectan a	E	Due to (or as	a consequence of):		
687	ficate physis the	Physician/Medical	d			
Вох	n certi	D/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome			23d. Date of delivery
	that the death certific ed by the attending pl detached for use as t	sicla	1 Yes 2 No 4 Pregnant at	2 ☐ Fetal death 3 ☐ Ectopic pregnancy time of death 5 ☐ Other (specify)		Month Day Year
P.O.	at the	Phys	9 🗆 Unknown		00 - Bidad	
	w requires that s been signed E should be deta	by	Part II. Other significant conditions contributing to death be	ut not resulting in the underlying cause given in Part I.		pacco use contribute to the cause of death?
Ö	v requ been shoulk	Completed by		· · · · · · · · · · · · · · · · · · ·		
Rec	he lav e has age 2	mp			24a. Was a autops perforr	y prior to completion of cause of death?
Division of Vital Records,		Be Co	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes :	2 No 1 Yes 2 No
Ž	Physicien: this certific	일	examiner? 1 Yes 2 No Hospital: 1 Inpatie			ence 6 Other (Specify)
0	ding Pt h. After tt funeral	on:	27. Manner of Death 28a. Date of Inju. 1. Natural 5 □ Pending (Month, Day	Year) Injury Work?	28d. Describe ho	ow injury occurred
Sio	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	20f Leasting (C)	and and blumber of Comb Could blumber
Divi	l or Ail after of Direct	ertif	4 Homicide determined 286. Place of Injury	ury - At home, farm, street, factory, office c. (Specify)	City or Town	reet and Number or Rural Route Number, n, State)
_	To the Hospitel or Attene within 24 hours after death To the Funerel Director: completely fi∥ed in by the	alC	29a. Certifying Physician: To the best	of my knowledge, death occurred at the time, date and place,	, and due to the c	ause(s) and manner as stated.
	he Ho in 24 i he Fu pletely	edical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or investigation, in my opinion, death occur	rred at the time, d	ate and place, and due to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	29c. License number	1	9d. Date signed (Month, Day, Year)
•	4			00060292	_	June 19 2005
	l	1	30. Name and address of person who completed cause of d		et Da	June 19 2005
	Sta	ate	3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ar's Signature	cet, Va	Trace Ply energ
	Regist		MIN 2 & and L	of books		
DH	IMH 17 Rev 1/2	001	0011 × 0 2003 / 1000			
				ORIGINAL		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 26, 2005 **Physician** 7:20 a M Wilma G. Watts /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Heritage Harbor Health & Rehab. Ctr. Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 29,1922

8. Birthplace (State or Foreign Country)
North Carolina 6. Sex **Funeral** Months Days Hours 1 □ M 2/□ F 245-24-0775 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Madical Examinar riust be notified at Completed by Funeral Director 1 X Yes 2 No Md. Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2518 Painters Court 21401 U.S.A. Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural', 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be r is marked o Russell L. Garland Daisy Marie Street ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Robert Watts- Husband 2518 Painter Court, Annapolis, Md. 21401 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Pleasant Grove Cem. June 30, 2005 Reisterstown, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liber see 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. 21102 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical for use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 Cher (specify) been signed by the should be detached 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 atural 5 Pending To the Hospitel or Attendin within 24 hours after death.

To the Funerel Director: Af completely filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23) (Type, Print) DSS Cherrolet Drive Ste NO Elliwhaty woldon V) IDE KA 9+1 31. Date filed (Month, Day, Year) 32. Sgistrar's Signature State Registrar

			1 - State Amend Item 23a Ragistrar 1. Decedent's Name (First, Middle, Last)	State of Maryland / Depa a-c&25 per me G846 &	rtment of Health and M 10-05 tas tificate of Death		ne №2005	2111.1
	Physici /Medic		VIRGINIA			2. Date of Death Month	Pay 17 Year 2005	S. 30A.M
'	Examir			PMAL	4b. City, Town, or Location of Death RANDAUSTOWN		4c. County of Death BALTIM ORT	<u> </u>
Ì	Funeral Director		5. Social Security Number 6. Security Number 10 Usual Residence of Decedent	7. Age (In yrs. last birthday) M 28 F 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. 11 • 03 • 19	ar) 9. Birthp Cour	place (State or Foreign htry)
	death with the Maryland ms 23e or 28e-f show final be notified at	or	10a. State 10b. County MD BATIMO	10c. City, Town or Lot ORE GWYNN	oation OAK		1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-	Director	10e. Street and Number	4.001010	10f. Zip Code	10g.	Citizen of What Cour	
	s 23e		2120 LUKEWOOD	DRIVE	21207		USA	
920	or Ite	by Funerai	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	1 ☐ Yes 2 KNo	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto f ☐ Yes 2 【 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
15-0	"natur	ieted	15. Decedent's Edu (Specify only highest grade	e completed) (Give	ent's Usual Occupation kind of work done during most of workir IO NOT use retired)	ng 16b.	Kind of Business/In	
212	be filed within 72 ha ital Hyglene. id other then "netui evsnt, the Medical	Completed	BIH GRADE	College (1-4or 5+)	EMAKER		DOMESTI	C
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be (17. Father's Name (First, Middle, Last) HUDIE BEA		18. Mother's Name FANNIE	(First, Middle, Maid		
Mar	s 1 end 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty) FERIEV YERBY		g Address (Street and Number or Rura.	I Route Number, Cit BALTO . M		Code)
ore,	permit. Pages 1 end 2 Department of Heaith a Important: If Item 27 is any Injury or other tra once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R	20b. Place of Dispos cemetery, crem	sition (Name of patory or other place)	ate 20c.	Location - City or To	wn, State
Baltimore,	artment brtant: brtant: Injury o		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	SHIMH RAI		2.05 RE		VA
Ba	Depa Impo any I		1 Vayon C	/ VAI	Name and Address of Facility USHN C. CREENE FU 51 BAUO. NATL' PIKE	LIVERAL SE	RVICE 40 21229	
	Physician		23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		or the mode of dying, such as cardiac or		· 1	Approximate Interval Between Onset and Death
ı	/Medical Examiner			Due to (or as a consequence of): WOUND INFE	chon //	47,	+	VECKS
	ed sit	iner	Sequentially list conditions, if any leaching to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	IRITIC E	APPROVED BY MEDICA	LEXAMINED	Ann Dix.
8760,	death certificate be executed e ettending physician and id for use as the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):	V)2[] 02	Bhu.		10/1/11/5
9	rtificate ng phys as the	dedical	IF FEMALE:					
P.O. Box	that the death certificated by the ettending properties as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
	w requires that the been signed by th should be detache	ed by Ph		stributing to death but not resulting in the un VS , $CHROMCRE$		23e. Did tobacc	o use contribute to th	e cause of death?
Vital Records,	e law has b	Completed by	CARCINOMA BR	EST		24a. Was an autopsy performed?	prior to cor death?	osy findings available inpletion of cause of
/ita	Physician: Th this certificete ral director, pag	BeC	25. Was case referred to medical examiner?		26. Place of Death			20.10
of	Phys this al di	: To	1 ▼ Yes	ospital: 1 Department 2 EN/Outpatient 2 Seb. Time of (Month, Day Year) 1 EN/Outpatient 28b. Time of Injury	The state of the s	ne 5 Residence 8d. Describe how in	6 Other (Specify	')
Division of	Attending r death. sctor: After y the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Divi	To the Hospital or Attending F within 24 hours after death. Yo the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		City or Town, Sta		
•	hs Hosp in 24 hou he Funei pletely fil	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicat Examir	sician: To the best of my knowledge, death nar: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, an estigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
	To t To t	\sim	29b. Signature and title of certifier ROUSE	nagan M.D	29c. License number	29d. C	Date signed (Month, L	Day, Year) 2005
	0		30 Name and address of person who co	mpleted cause of death (Item 23a) (Type, F	continued Hoppi	tal cent	es	
B	Sta Registr	re l	31. Date filed (Month, Day, Year) JUN 2 7 2005	2." Registrar's Signature	W			

			1 - For Amend Item	State of l	Marylan ME,G 8	d/Depa 45,077	rtment of H 15/05dhb tilicate of	lealth and I	Mental Hy	giene	000=	•
Ī	Physici	2.5	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	-	Year	5: Time of Death2
	Physici /Medic	al	4a. Facility Name (If not institution, give s	AMES E		40PD			JUNE 6	2	005	9:16 A M
	Examin	er	CARROLL HOSPITA		•		·	Location of Death			County of Death CARROLI	
Ī	Funeral		5. Social Security Number 6. Sex	7. M 2□F	Age (In yrs. i	3.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	h y, Year)		lace (State or Foreign
	Director		212-24-5529 Usual Residence of Decedent		8	2 Yrs.			7/17/1	922	MAR	LAND
	show	ŗ	10a. State 10b. County MD CARROLI			y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2X No
	r 28a-f	Director	10e. Street and Number	•			10f. Zip Code			10g. Citiz	en of What Cour	
	death with the Maryland ms 23a or 28a-f show Frinst Le rivilland at		1509 MARIE COUR	Т			2104	18		US	SA	
_		Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decede Armed Force 1 ☐ Yes 2.	es?	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	- 1	 Race - Americ Black, White, 	
200	hours after tural; or ita	by	3 Nidowed 4 Divorced	If Yes, Give Year or Date	-	1	☐ Yes 2X No	Specify:			Specify: WHI	TE
2	22 82	ompleted	15. Decedent's Educ (Specify only highest grade	completed)		(Give	ent's Usual Occup kind of work done o OO NOT use retired	during most of wor	king	16b. Kin	d of Business/Inc	lustry
7 7	ad within giene. er than "	Comp	Elementary/Secondary (0-12)	College (1-4	or 5+)			CK DRIV	ER	MAN	UFACTU	RING
ana	I be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)	BAYARD	ARNO	LD		18. Mother's Nan	ne (First, Middle,		Sumame) RR	_
ary	d 2 should by th and Menta 7 is marked traumatic e	T ₀	19a. Informant's Name/Relationship (Typ	oe, Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe			Code)
ž	s 1 and 2 f Health s item 27 is other tre		JOYCE F. GARBER	- DAU		-		COURT,				
	8°2 = 5		20a. Method of Disposition 1	emoval from Sta	ate C	emetery, crem	sition (Name of natory or other place	´ I	Date / O F		ation - City or To	
Daltim	permit. Pa Departmer Importent: any Injury		21. Signature of 5-1914 Service License	9	EVER		MEM . GA			FUN	KSBURG ERAL H	, MD. OME
	50E 2 8						54 E. M.				ER, MD	
	Physician		23a. Part Inter he disease, or complice shock, or he in the lare. List only on immediate Cause (Final	e cause on eac	n line.					_	(,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or	as a consequ	uence of):	NCHY	MIJC 104	EED (BKA	9/N)	1 DAY
	Cxammer	ē	Sequentially list conditions, b. if any, leading to immediate	Due to (or	as a consequ	uence of):						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							11	1/	
8/00,	cate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or	as a consequ	uence of):		U	M	FORALE	XAMINER	
00	hy he	ledical	d.					CERTIFICATI	N APPROVED BY			
X O D	death certific e attending pl of for use as t	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 Fetal	death 3 🗌	Ectopic pregnancy	CEKIII.			3d. Date of delive	ry Day Year
5		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□ Unknow	t at time of de	eath 5	Other (specify)				Wilding	ouy roar
ν, Γ	law requires that the de as been signed by the a 2 should be detached	by PI	Part II. Other significant conditions con-	tributing to deat	h but not resu	ulting in the un	derlying cause give	en in Part I.			_	e cause of death?
cords	requir been si should	eted			·					es 2		ably 4 □Unknown
Ž	The law cate has I page 2 s	Completed							24a. Was a autop: perfor	sy med?	prior to con death?	osy findings available inpletion of cause of
Ital	sician: The lav certificate has rector, page 2	BeC	25. Was case referred to medical examiner?						th (Check only or	2 No ne)	1 🗆 Yes	2 L No
ō	Physic ruthis rail di	1	1) Yes ZZ No 27. Manner of Death	ospital: 1/2 Inp. 28a. Date of I		ER/Outpatient		4 Li Nursing n	ome 5 Resid)
00	or Attanding F ifter death. Diractor: After in by the funera	atlor	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	28c. Injury Work	? res 2 □ No	200.000.00	ov anjuly	00001100	
MVISION	or Atterdenter de Diracto	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At ho , etc. <i>(Specif</i> y	me, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Rura	Route Number,
_	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu		29a. Certifier Certifying Phys	icien: To the be	est of my know	wledge, death	occurred at the time	e, date and place	, and due to the o	ause(s) a	and manner as st	ated.
	the Ho hin 24 tha Fu mpletel	Medical	(Check only one) 2 Medical Examin 29b. Signature and tipe of certifier	er: On the basi and manner	s or examinar	ion and/or inv	estigation, in my of	oinion, death occu	rred at the time, o	date and p	place, and due to	the cause(s)
	2 1 2 0		29b. Signature and the or define	0/2/	1	7.0.	29c. License				signed (Month, I	
	MJ3		•	npleted cause of			Print)			-	19	
	Sta	te	GOURISHANKAR 31. Date filed (Month, Day, Year)	C . 32. Req	NAO isy ar's Signat	ANN ture	A 7001	g pool	ERD U	NEST	MINSTER	205 2 MD 21157
	Registr		JUN 0 9 2	2005	leve	K	books					

				State of Marylan				-	_	•
			For State Registrar	3.0.0 G. , , to	-	rtificate of L			.n2005	21143
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Ollie James All 4a. Facility Name (If not institution, give			Ab Cib. Town	Location of Death	June 4,	2005 4c. County of De	10:08 a M
	Examin	er	Summerville at We			Westmi:			Carrol]	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		irthplace (State or Foreign Country)
	Director		252-22-1939 Usual Residence of Decedent	x ^{M 2□ F} 91	Yrs.	Michael Buyo	110010			Lssouri
	yland Now		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Ba-fsh	ctor	Maryland Carroll	We	estmin	ster				1 ☐ Yes 2%∑ No
	with th	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What (Country?
	ns 23	Funeral	807 Boxcar Dr 11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	211 Was Decedent of Hi			USA 14. Race - An	nerican Indian,
9	or Iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give	i	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wr	nite, etc.
003	ural',	d by	3 ØWidowed 4 □ Divorced	Year or Dates:		1□ Yes 2□ No			Specify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show ta Mudical Existing to ast be inclified at	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work ()	ing	6b. Kind of Busines	s/Industry
212	giene.	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		Engineer			Westingh	ouse
nd	be filed ital Hygird of other event, II	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	,	
3	should nd Mer marke umatic	10	George Allen 19a. Informant's Name/Relationship (7)	(vne Print)	19h Maili	ng Address (Street a		Truester		Zin Codo)
	nd 2 lith a 27 is r tra		Kelly M. Allen	Son		Boxcar Dr		minster,		
ore,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition	20b. P	Place of Dispo	osition (Name of matory or other plac	e)	Date 20	c. Location - City o	or Town, State
Ë	Pages ment of ant: if it		1 ☐ Burial 2 🏋 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval Hom State	rroll (Cremation	Inc 6/6			Maryland
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licen	300	2:	2. Name and Addres 12 Washin	ss of Facility Prid aton_Rd_	ts Funer	al Home {	Chapel, PA
I,			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death	h. Do not en	ter the mode of dyin-	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Colon	(or	reinos	ma			Oliser and Death
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	B =	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Dae to (or as a conseq	uence of):			-		
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760,	sician and burial-transit	cal E		Due to (or & a conseq	dence oi).					
68	<u> </u>	ed		d					1	
Вох	eath certificat attending phy I for use as th	an/M	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnancy			23d. Date of d	
O. E	The law requires that the death certifica te has been signed by the attending ph tage 2 should be detached for use as it	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown		Other (specify)		-	Month	Day Year
Δ.	that the de led by the a detached t		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	ınderlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
rds	w requires been sign should be	ed by	Atma	1 216m	lac	ion		1 ☐ Yes	2 □ No 3 □ I	Probably 4 Unknown
Records,	e taw requ has been je 2 shoul	Completed	Arterio.	echioli	((cleses	ru	24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
E B		Соп						performe	No 1 Ye	?
Vital	Physician: this certificar ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:	LEDIO	Othe	-	h (Check only one)		
of	g Physier this	-	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	28b. Time o	The second secon	v at	ome 5 Residen		necify)
sion	ath. r: Aff	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 □ No			
Division	tal or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Number or i State)	Rural Route Number,
	Hospil 4 hour Funera ely fille	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exem	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/. //-		29c. License	e number	290	d. Date signed (Mo	nih, Day, Year)
)	NJL		> KVaol	malla R.	Tadim	alla Do	00582	246	6/6/	2005
	5		30. Name and address of person who	ashingto	n	Rd R	hesi	mine	ten	M) 21157
	Sta Regista		31. Date filed (Month, Day Year) 0 8	32. Registrat's Signation		Socile				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registre Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Cleophas Ewell Bennett June 11 2005 10:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner
 Salisbury
 W1

 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)
 Wicomico Nursing Home Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral 10XM 2□ F 90 Director 222-03-0899 14,1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event. The Medical Examiner must be notified at 1X Yes 2 No Director Maryland Wicomico Sharptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e 500 Taylor Street 21861 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 194. 1 XYes 2 No If Yes, Give Year or Dates: 194. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1942-72 hours after 1 Never Married 2 X Married ö 1945 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White neturel 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Wholesale Candy Co. 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William James Bennett Lucy Holmes Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley F. Bennett/Wife P. O. Box 127, Sharptown, Maryland 21861 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Sharptown Firemens Cem. 6/15/2005 * 4 □ Donation 5 □ Other (Specify) Sharptown, Maryland 21. Sign ture of Dineral Service Light Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Party. Enter the disease, or complications that speck, or heart failure. List only one cause on used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ALLURE MAINE disease or condition resulting in death) Due to (or as a consequence of) Sec if ar cau that Examiner res Physician/Medical use as the IF F 23h Part ģ (Completed

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

the Hospitel or Attending Physicien: The law requires that the death certificate be executed After after death Director: within 24 hours a

25. Be

Mahesha Thimmarayappa, M.D.

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (pisease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of delivery Month Day Year
,	ntributing to death but not resulting in the underlying cause give	in Part I.	23e. Did tobacco	use contribute to the cause of death?
COLONARY	ARTERY DISEASE		1 ☐ Yes 2	□No 3□ Probably 4 Nuknown
HYPERTENSION	V		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
TYPE 2	DIABETES		performed?	death?
25. Was case referred to medical examiner?		26. Place of Death (0	Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	4 Nursing Home	5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury Work' M 1 T	at 286 es 2 □ No	d. Describe how inju	ry occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28	f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
29a. Certifying Phy (Check only one)	sician: To the best of my knowledge, death occurred at the time. ner: On the basis of examination and/or investigation, in my opi and manner stated.	e, date and place, and nion, death occurred	d due to the cause(s at the time, date and) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier	v.T MD D-0	060515	29d. Da	ate signed (Month, Day, Year)

614 Easternshore Drive, Salisbury, MD 21804

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Brodie 2005 John /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mary land Medical Center of Baitmore ハロ University If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 15 M 2□F 26, 1918 Director 87 Oklahoma 383-05-3268 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Dorchester Toddville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1825 Crocheron Road 21672 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify white WWII ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Man Elementary/Secondary (0-12) College (1-4or 5+) fender and body repair automotive 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Wesley Brodie Eldora Bertie Mooney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley Brodie 1825 Crocheron Road, Toddville, son MD 21672 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Thomas Churchyard 6/14/05 4 ☐ Donation 5 ☐ Other (Specify) Bishops Head, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Kneumoni /Medical Due to (or as a consequence of): Examiner nterstital Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan certificate has autopsy performed? Yes 2 No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No npatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification; To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation filled in by the hours after deat ineral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar Angela Month.

P18543

June 9,2005

Skeet, Baltimore, MD 21201

MD

2 South Greene

32. Recentrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	For State of Maryla	and / Department of Health and N Certificate of Death	Mental Hygiene	21116
	Registrar Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. N2 0 0 5	21146
Physician /Medical	Margaret Marie Bohlen		Month Day Year	3. Time of Death
Examiner	. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	Dorchester General Hospital	Cambridge	Dorches	ter
Funeral Director	Social Security Number 219-14-4728 6. Sex 1 M 254F 78 78 10 M 254F	rs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. Birth, Cow July 20, 1926 Ma	place (State or Foreign ntry) ryland
Maryland all filed at	The state of the s	City, Town or Location Cambridge		10d. Inside City Limits 1 Yes 2 No
6 Rell State of the Manager of the M	e. Street and Number 1406 Hambrook Blvd.	10f. Zip Code 21613	10g. Citizen of What Cour	ntry?
536 at 823	. Marital Status 12. Was Decedent Ever in		ecify Yes or No- 14. Race - Americ	can Indian
93, W.S.	Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 195	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, Specify: Wh:	etc.
21215-003 ed within 72 hours a ygiene. narthan "natural", of it, the Medical Exan	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business/In	dustry
212 2 with giene.	Elementary/Secondary (0-12) College (1-4or 5+) 11 4	registered nurse	hospital	
Bohlen, Maryland 21; Maryland 21; and 2 should be filed wit no T is marked other the ar traumatic event, the To Be Com	. Father's Name (First, Middle, Last) Christian C. Wilson	18. Mother's Name Ethel	e (First, Middle, Maiden Surname) Meise	
Mary Mary nd 2 shou	Ba. Informant's Name/Relationship (Type, Print) Sandra Bohlen daughter	19b. Mailing Address (Street and Number or Run 102 Woolen Mill Road,		
Baltimore, sermit. Pages 1 at Department of Heamportent: If Item my prize it it item my lijury or othe pines.	a. Method of Disposition 20b 1 Disposition 3 Removal from State		Date 20c. Location - City or To	own, State
Itim ii. Pagartment artment: ortant:	* 4 □ Donation 5 □ Other (Specify) MO: 1. Signature of Funeral Service Licensee	reland Memorial Park Cem.	6/16/05 Baltimore omas Funeral Home P.	
Bal permi Depa Impo any i	Brick. But	700 Locust St., Cam		.A.
Physician	3a. Part1. Enter the disease, or complications that caused the de shock, or hearf failure. List only one cause on each line. mediate Cause (Final sease or condition	eath. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner	Due to (or as a cons			34000
ed ed	equentially list conditions, b. Due to or as a consultate. Disease or injury at initiated ayears	actianga of):) y cois
8760, ate be executed hysician and the burial-transit	at initiated events c	equence of):		
Records, P.O. Box 6876 The law requires that the death certificate to the has been signed by the attending physic page 2 should be detached for use as the bombleted by Physician/Medical completed by Physician/Medical	FEMALE: bb. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	etal death 3 Ectopic pregnancy	23d. Date of delive	ery Day Year
E 9 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	rt II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the	ne cause of death?
Cords **requires been sign should be	uterine concer		1 ☐ Yes 2 ☐ No 3 ☐ Prob	ably 4 Unknown
Division of Vital Records, for Attending Physician: The law requires taller cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes	psy findings available mpletion of cause of 2 No
Vital F ician: Th certificate rector, pag	Was case referred to medical examiner?		n (Check only one)	
of Vital Physician: rthis certifica		☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Ho 28b. Time of 28c. Injury at	me 5 Residence 6 Other (Specify	y)
On of ding Physis. After this funeral di	1 ☑Natural 5 ☐ Pending (Month, Day Year)	28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
Division of the or attending P at a first death. al Director: After ed in by the funer. Certification:	office state of Could not be	home, farm, street, factory, office	28f. Location (Street and Number or Rura City or Town, State)	l Route Number,
Division of Vital Re To the Hospital or Attending Physician: The Within 24 hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	Da. Certifier (Check only one) 1. Certifying Physician: To the best of my k 2. Medical Examiner: On the basis of examinand manner stated.	nowledge, death occurred at the time, date and place, nation and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as st ed at the time, date and place, and due to	ated. the cause(s)
To the within round the complex of t	b. Signature and title of certifier	29c. License number	29d. Date signed (Month,	
	Pfahrian	H005997	5 6/11/03	5
	Name and address of person who completed cause of death (It	em 23a) (Type, Print) Branble St Cambri	dge MD 210	613
State Registrar	Date filed (Month, Par Year) 4 2005 32. Redistrar's Sig	nature		

			1 - For State Registrar	State of	of Maryla		artment of F		Mental Hygid	ene 200	5	21147
			1. Decedent's Name (First, Middle	, Last)					2. Date of Death			3. Time of Death
	Physicia /Medic		June Elinor	Biedlingm	aier				June 11,		Year	7:30P M
	Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death	1	4c. County o	f Death	
			Laurel Regi					ırel		Princ	e Ge	eorges
	Funeral Director		5. Social Security Number 193-12-3541	6. Sex 1 ☐ M 2 🕅 F	7. Age (In y	rs. last birthday) 1 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Aug. 27, 1	923	9. Birthp Coun PA	lace (State or Foreign try)
П	D .		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	agation.					Od Inside Chatteria
	sho	'n		e Georges	ŧ	Laurel						0d. Inside City Limits 1 X Yes 2 □ No
	the A	ect	10e, Street and Number				10f. Zip Code		100	g. Citizen of WI	hat Cour	
	3a or	Funeral Director	9332 Palmer Pla	ace			207	7N8		USA	101 00011	,
	ms 2	era	11. Marital Status	12. Was Dec	edent Ever in		Was Decedent of H	lispanic Origin? (St	pecify Yes or No-	14. Race		an Indian,
200	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or items 23s or 28s-f show other treumatic event, Ite Madrel Examinat must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Fi	2∰ No ive	-	If Yes, specify Cuba 1 ☐ Yes 2 XNo	an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	, White, o Wh	etc. nite
5	2 ho	ted	15. Decedent		,	16a. Dece	dent's Usual Occup	ation	16	6b. Kind of Bus	iness/Inc	dustry
7	thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)	lite.	kind of work done DO NOT use retired	during most or world)	King			
7	ed wi ygien ner th it, Ine	Co	12			H	omemaker				Home	<u> </u>
	ntal H ed oth	Be	17. Father's Name (First, Middle,	Last)					ne (First, Middle, Ma)	
Š	hould d Me mark matic	٦ ر	Harold Reif 19a. Informant's Name/Relationsl	nin (Tuna Print)		10h Maili	na Address (Street		rude Meen		State Zin	Code
ַ -	id 2 s ith an 27 is i		James Biedling		on				Westmins	-		
D,	tem 2		20a. Method of Disposition			. Place of Dispo	sition (Name of			Oc. Location - C		
2	Pages ent of nt: if i		1 ☐ Burial 2 XCremation 1 ☐ Donation 5 ☐ Other (S)		State H	untt Cr	matory`or other plac ematory	. 1	3/2005	Waldo	orf,	MD
Daillinor	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre 2008.		21. Signature of Funeral Servic	icensee			2. Name and Addre	ss of Facility Rol	bert E. E			
	8		23a. Part1. Enter the disease, or	complications that	caused the de		16000 Ann			e, MD 2	:0715	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	Thromb		3 ,	,,			Interval Between Onset and Death
	hysician /Medical	8	disease or condition resulting in death)	a	(or as a cons					71	- 111	inutes
	Examiner				(0. 00 0 00.00							
	п =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a cons	sequence of):						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
9/00,	cian a	al E)	rooding in doding East	Due to	(or as a cons	equence of):						
0	licate be executed physician and s the burial-transit	edical		d								
XO	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pre-	gnancy				23d. Date	of delive	any.
	w requires that the death certil been signed by the attending should be detached for use a	Physician/M	in the past 12 months?	1☐Live 4☐Preg	birth 2 ☐ F nant at time o	etal death 3	Ectopic pregnancy Other (specify)	′		Mont		Day Year
	t the by the ache	hys	9 ☐ Unknown	9□ Unkr	nown							
Ď.	es tha gned	by P	Part II. Dther significant condition	_		-	nderlying cause giv	en in Part I.	23e. Did toba	cco use contrib	oute to th	ne cause of death?
corus,	equire		Rupture Abdomi	nal Aort	ic Ane	urism	<u> </u>		1 ☐ Yes	2 □ No 3	X Proba	ably 4 □Unknown
ວັ	law r as be	Completed	,						24a. Was an autopsy	pr	ior to con	psy findings available inpletion of cause of
	The cate h	Con							performe	ed? de	eath?	
VII G	icien: certific ector	Be	25. Was case referred to medical examiner?				Oth		th (Check only one)			
5	Attending Physicien: It death. sector: After this certifically the funeral director.	To:	1 Yes 2 X No 27. Manner of Death	28a. Date		ER/Outpatie		4 Nursing H	ome 5 Residen 28d. Describe how			"
5	ding h. After funei	tion	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	g (Mor	nth, Day Year) Injury	Wor	k? Yes 2 □No	200. Describe now	injuty occurre		
VISION	Attending PI r death. sctor: After they the funera	ifica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place			reet, factory, office		281. Location (Stre		r or Rura	I Route Number,
5	el or s afte ol Dire	Certification;	4 Homicide determ	build	ding, etc. (Spe	ecity)			City or Town,	State)		
	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai (29a. Certifier 1 Certifyin (Check only one)	Examiner: On the t	e best of my i basis of exam nner stated.	knowledge, deat ination and/or in	h occurred at the tire vestigation, in my o	ne, date and place	, and due to the cau rred at the time, dat	ise(s) and man e and place, ar	ner as stand due to	ated. the cause(s)
	omple	Me	29b. Signature and title of certifier		7, 1		29c. Licens	e number	290	d. Date signed	(Month, I	Day, Year)
	->-0		> 11/11/ca	i /+//	()ar	renth	un i	1175/1	0 1	un !	1.2.	2005
			30. Name and address of person	who completed cau				, , , , ,			-	5 000
			William A. Wa					Street La	aurel, MD	20707		
	Sta Registr		31. Date filed (Month, Day, Year)	3 2005	Registrar's Signature	gnature	book					

			1 - State State Registrar	•	artment of Health and I		ene • • • • • • • • • • • • • • • • • • •	2111.8
	Physici	an	Decedent's Name (First, Middle, Last) Marsy, E. Rogyon			2. Date of Death Month		3. Time of Death
	/Media	al	Mary F. Beaver 4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of Deatl	June	6 2005 4c. County of Deat	2:00 A M
	Examir	lei	Fox Chase Nursing H		Silver Spr		Montg	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 万 F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sep. 24,	Year) 9. Birth Co W. 1944 W.	hplace (State or Foreign untry) ash., DC
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or La	cation			10d. Inside City Limits
	e Mar	ctor	DC		Washington	1		1 AYes 2 No
	with th	Director	10e. Street and Number	nd Terr., SE	10f. Zip Code 20020	10	g. Citizen of What Co	
	ns 236	Funeral	11 Marital Status 12, Was De			pecify Yes or No-	14. Race - Ame	States
21215-0036	be filed within 72 hours atter death with the Maryland ital Hygiene. did other than "neturel", or items 23a or 28a-f show svent, the Medical Exerting country that the traiting at	by	Armed	2 TNo Give	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ĀNo Specify:	o Rican, etc.)	Black, White	
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed	f) (Give	dent's Usual Occupation kind of work done during most of wor	rking 10	6b. Kind of Business/	Industry
121	within ene. than	Completed	Elementary/Secondary (0-12) College	(1-4or 5+) life. I	DO NOT use retired) Beautician		Priva	3.4.6
d 2	Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma		ate
/lan		To B	David Beave	er		Mary M	lorton	
Maryland	2 6 50 50		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Ru	ral Route Number,	City or Town, State, Z	(ip Code)
	s 1 and 2 if Health item 27 l		David Beaver - Son 20a. Method of Disposition	20b. Place of Dispo	04 Suitland Terr.		sh., DC 20	
altimore,			1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	n State	natory or other place) od Cemetery 6/1	1/2005	Wash., I	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Fureral Service Licensee			tewart Fu	neral Home	2
			23a. Part1. Enter the disease, or complications that shock or heart failure. List only one cause on	caused the death. Do not enti-				Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	Cirrhosis			4	Onset and Death 6 Months
	/Medical Examiner		resulting in death) Due to	o (or as a consequence of);				
	3 6 7 1	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a consequence of):				
	ecuted ind transit	Examl	that initiated events c.					
8760,	cate be executed bhysician and the burial-transit	al Ey	Due to	o (or as a consequence of):				
687	as 년 는	edlcal	d					
Вох	death certifi e attending I id for use as	an/M	23b. Was decedent pregnant	utcome of pregnancy birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deli	,
	0 0	Physician/M		nant at time of death 5	Other (specify)		Month	Day Year
S, P	es tha igned be de	by	Part II. Other significant conditions contributing to		nderlying cause given in Part I.		acco use contribute to	
Records,	w requir been s	ompleted	Chronic Renal				2 No 3 Pro	A
Rec	The law ate has page 2 s	lduic	Diabetes Melli	tus		24a. Was an autopsy performe	prior to c ed? death?	topsy findings available completion of cause of
Vital		Oe	25. Was case referred to medical		26. Place of Dea	th (Check only one)	Δ	2 No
of V	S 00 0	To B	examiner? 1 ☐ Yes 2 🔀 No Hospital:	Inpatient 2 ER/Outpatien	Othor			ify)
			1 Natural 5 ☐ Pending (Mo	of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how		
Division	deat deat ctor: y the	ertiflcatlon;	2 Accident investigation 3 Suicide 6 Could not be	ee of Injury - At home, farm, stre	M 1 ☐ Yes 2 ☐ No	28f. Location (Stre	et and Number or Ru	ral Route Number
Σ	in Direct		4 Homicide determined buil	ding, etc. (Specify)	on, radiory, ornog	City or Town,	State)	ra riodio vallisci,
	Hos Fur y	edical C	(Check only / 2 Medical Examiner: On the	ne best of my knowledge, death basis of examination and/or inv nner stated.	occurred at the time, date and place restigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2.	W	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month	
,	1. Hu		edis-		D28656		June 9	, 2005
			30. Name and address of person who completed car Ravi Passi, M.				MD 2001	0
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signature	ve., #404B, Silve	r spring,	MD 2091	U
	Registr		MON T 3, 5002	on & Som	les			

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

David Granite, 000 115 Conterway greenbelt, 100 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JUN 13

Please

Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of He	ealth and Mental Hygiene
Certificate of D	Death Seath

		ŕ	1 - State Registrar	state of Ma	aryland / Depa <i>Cel</i>	artment of H rtificate of L				~
	Physici	an	1. Decedent's Name (First, Middle, Last)	te Banl						C3. Timelof Da
	/Medic	al	Charlotte Jeanet		\S 	4b Cib. Taur	Lastina of Bank	June 0	6 2005 Year	8:40 A M
	Examin	er	4a. Facility Name (If not institution, give str Prince Georges Comm		spital	46. City, Town, or Chever	Location of Death		4c. County of Deat Prince G	
	Funeral Director		377-70-0939	7. Age	(In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 07/09/1	9. Birt 958 Wast	hplace (State or Foreign unity)
	land ow		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	a-f sh	tor	MD P.G.		Hyattsv	rille				1X Yes 2 □ No
	vith the	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ns 238	eral	3605 Warner Avenue	. Was Decedent 8	verical S 13 1	20784		ocify Vac or No	U.S.A.	rican Indian
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	lo	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2☐ No	Specify:	Rican, etc.)	Black, White	
5-0	72 hc "natu	leted	15. Decedent's Educa (Specify only highest grade of		(Give	dent's Usual Occupa kind of work done of	luring most of worki	ing 1	6b. Kind of Business/	Industry
2121	within lene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5 3yrs	+)	DO NOT use retired, Prvice Tec			Verizon	
Maryland 21215-0036	should be filed and Mental Hygie marked other i matic event, II	To Be C	17. Father's Name (First, Middle, Last) Stanley K. Watsor				18. Mother's Name	o (First, Middle, M		
	nd 2 ilth ai		19a. Informant's Name/Relationship (Type James L. Banks -						City or Town, State, 2 SVille,	
Baltimore,	m O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	noval from State	20b. Place of Dispo cemetery, crer		e) [Oc. Location - City or	
Iţim	permit. Page Department of Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee			ran Cem				, Maryland
Ba	Depa Impo		· gendantile	nar)					aryland 2	0752
	Blacelatan		23a. Parti. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final					or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	METASTA Due to (or as	a consequence of):	LON CA	NOCK			
	Examiner	L	Sequentially list conditions, b.							
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a	a consequence of):					
oʻ	rificate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
68760,	cate be	edical	d.							
.O. Box 6	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Δ.	res that igned by	by Ph	Part II. Other significant conditions contr	buting to death bu	it not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords	w require been sig should b							1 🗆 Yes	2 No 3 Pro	obabły 4 Unknown
of Vital Records,		Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
Vita	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	spital:		t 30 pos Othe	26. Place of Death			
of	Phy this ral d	n; To	27. Manner of Death	1 ∐ Inpatie	y 28b. Time of	28c. Injury	at 2	ne 5 🗌 Resider 28d. Describe hov	nce 6 Other (Spec v injury occurred	elfy)
sior	Attending Products of death.	catlo	1 Natural 5 Pending 2 Accident Restination	(Month, Day	Year) Injury	M 1 □ Y	es 2□No			
Division	tal or Attend is after death sl Director: , ed in by the f	Certification	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, str :. (Specify)	eet, factory, office	1	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or a within 24 hours after or the Funersi Direction Completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physi 2 Medical Examine	r: On the best of r: On the basis of and manner sta	of my knowledge, death examination and/or in- ted.	n occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
		Σ	29b. Signature and title of certifier	X	~	29c. License			d. Date signed (Month	
,	(10)		30. Name and address of person who com	pleted cause of d	path (Item 23s) (Turn		0592		6-8-0	5
	JC		DR NEAL SIKKA	Je Je	of Hospital		C	HEVERLY,	6-8-0 MD 20	185
	Sta Registr	_	JUN 1 3 2005	32. Registra	r's Signature					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 9, Sadie Victoria Brissett June 2005 10:10 A.M. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Prince George's Hyattsville Sacred Heart Home, Inc. If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 ☐ M 2 🔀 F 95 Yrs Director 225-40-8958 7/10/09 Brunswick Co., Va Usuel Residence of Decedent permit. Pagas 1 end 2 should be filad within 72 hours aftar death with the Maryland Department of Heelth end Mentel Hygiene. Important: If frem 27 is marked other than "nature!" ---" any injury or other traumetic average. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1y⊈ Yes 2 □ No **Funeral Director** D.C. Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4410 19th Pl., N.E. 20018 U.S.A. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: American Completed by 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Secretary years 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma J. Stith Edward P. Bruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4410 19th Pl., N.E., Washington, D.C. Betty W. Weaver/Niece 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westchester, Pa. Rolling Green Mem. Park 6/16/05 21. Signature of Funeral Service Licenses H.S. Washington & Sons Co., Inc. aug nau 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Pert1. Enfer the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 1 Day Sepsis Examiner Due to (or es e consequence of): by Physician/Medical Examiner Pneumonia 1 Day To the Hospital or Attanding Physician: The law requiras that the death certificeta be executed within 24 hours eftar death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funaral director, page 2 should be datached for use as the burial-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? XX No 1 Yes 3 □ Probably 4 □ Unknown Dehydration 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy Dementia 1 ☐ Yes 2 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19609 June 10,2005 alwan ess of person who completed cause of deeth (Item 23a) (Type, Print)

Registrar

Raman R. Tuli, M.D. 3503 Perry Street, Mount Rainier, Md.

32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Buckner orman 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gounty of Death **Examiner** rince Georges heven rince Georges emmuni If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 577-42-2505 Director Lunuary 20, 1933 Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28s-t show the Medical Examination round be notified at Ma. 1 2 Yes 2 No Funeral Director rince 10e. Street and Number 10g. Citizen of What Country? 20743 6106 permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "Tratural", or Itema 23 any njury or other traumatic event, I'm Medical Exam. As must 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ ⊀o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 4 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) endor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be W. James 19b. Mailing Address (Street and Number or Rural Route Number, 530/ Lanham Station) 19a. Informant's Name/Relationship (Type, Print) Coad Harry 20a. Method of Sisposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Harmony Hemor 4 □ Donation 5 □ Other (Specify) 140e 16,200S Landove 21. Signature of Funeral Service Licensee Willeam 16 tre 20003 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 20 disease or condition resulting in death) /Medical **Examiner** Cancer Sequentially list curditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding to detail I act. Examiner or Attending Physician: The law requires that the death certificate be execut for use as the burial-tran resulting in death) Last Due to (or as a so sequence of) P.O. Box 68760, attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown cate has been signed by page 2 should be detact Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 1 Yes 2 🗷 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral dir Inpatient 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation 1 Yes 2 No death. 2 Accident whin 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06-08-*り003471*2 Hnnapolis address of person who completed cause of death (Item 23a) (Type, Print) 56 ne and KEN HIKIAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 13 2005 Registrar

ORIGINAL

			1 - For Stata Registrer	State of M	Marylan		artment rtificate					Reg. N		15_	21153
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of Dea	Da		Year	3. Time of Death
	/Medic	al	Walter S. 4a. Facility Name (If not institution, give	Banks	arl		4b Ciby 3	Foun or	Location of		June 9		005 c. County	of Dooth	10:20 am [™]
	Examin	er	2551 Murkle Rd.	, stroot and manner	·· /				ster	Dealli			•	rrol	1
-	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Birt	h		9. Birtho	place (State or Foreign
	Director		234-46-8294	∑ M 2□ F	88	Yrs.	Months	Days	Hours	Min.	(Month, Da Apr 3,			Coui West	Virginia
	pur k	-	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation							1	I Od. Inside City Limits
	Aaryla F sho	ъ													1 ☐ Yes 2½ No
	28a-	Directo	Wa. Jeffer: 10e. Street and Number	son	Sh	<u>epherd</u>	stown 10f. Zip	Code				10a C	itizen of W	Vhat Cour	ntry?
	3a or		29 Pearl Dr.					2544	3		İ		JSA		,
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or items 23a or 28a-f show event. If s Madical Examilian coust be multised at	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.				in? (Spec	cify Yes or No Rican, etc.)		14. Race		can Indian,
٥	or ite		1 Never Married 2 Married	Armed Force 1 ☐ Yes 24 If Yes, Give			iires,spec 1⊡ Yes 2		Specify:	, Pueno F	Rican, etc.)		Specify	k, White,	etc.
9500-612	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:									W	hite
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	withi iene. then	omp	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Heavy				rato	r		st Vi	-	ıa of Highways
2	other	a)	17. Father's Name (First, Middle, Last)			INCULY	<u>~</u> _u-	<u></u>			(First, Middle,				or mignway.
<u>a</u>		To B	Phillip A	Banks						Co	ra Jac	obs			
Maryland 2	2 should and Men is marke eumetic	Ï	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	ng Address	(Street a	ind Number	r or Rural	Route Numbe	er, City	or Town,	State, Zip	Code)
<u>~</u>	ges 1 and 2 should t of Health and Mer if item 27 is marke or other treumetic		Phillip A. Banks		Son	7223	Oak B	idge	Plac	e, C	hincote	agu	e, V	A 2	3336
0	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 🏚	Removal from Sta	ito	Place of Dispo cemetery, crei					ate			•	own, State
altimore,	permit. Pag Department Importent: I any njury o		* 4 □ Donation 5 □ Other (Specif	-	EL	mwood				6/13					n, WVa
Ba	permit. Pag Department Importent: t any injury o		21. Signature of Funeral Service Licer	l S			z. Name and	a Addres	s or racility	Prit	ts Fund	era]	L Hom	e &	Chapel, PA
	F = 5 1	2	23a. Part . Enter the disease, or com	plications that caus	sed the deat	41	2 Was	hing	ton R	d	westmi	iste	r, M	D 2	Approximate
Ē	Physician		shock, or heart failure. List only Immediate Cause (Final		n line.										Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. <u>CHF</u> Due to (or	as a consec	quence of):								-	5/11/05
	Examiner		Sequentially list conditions	b. Bact	terial	Pneum	onia								5/11/05
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consec	quence of):									
	and I-trans	Examine	that initiated events resulting in death) Last		al Fai										
8760,	cate be executed physician and the burial-transit	alE			23 2 GO11360	juditos orj.									
687	ficate p phys s the	edlcal		_ d											
Вох	leath certifics attending pt I for use as t	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75						23d. Dat	e of delive	ery
	death	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1⊟Live birth 4⊟Pregnan 9⊟Unknowi	t at time of c		□Ectopic pre □ Other (spe						Mor	nth	Day Year
<u>о</u>	that the de led by the a detached	Phys	9 Unknown												
	5 5 8		Part II. Other significant conditions of	ontributing to deat	h but not res	sulting in the u	inderlying ca	ause give	n in Part I.						he cause of death?
Orc	w require been sig should b	eted										195 2	2 🗆 No	3 FIOC	Jabiy 4 EGORKIOWII
Division of Vital Records,	has b	Completed									24a. Was		l p	Were auto prior to co death?	ppsy findings available impletion of cause of
a	iclen: Th certificate rector, pag		05.14								1 ☐ Yes	2 🔯 N			2 No
₹	ysiclen: The l is certificate ha director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 【★No	Hospital: 1 ☐ Inp	ationt 2	ER/Outpatie	nt 3 DO	Othe			(Check anly one 5 ☐ Residue)		e 63 0#.	CAre	givers
0	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of I		28b. Time o		8c. Injury Work	at		8d. Describe				misesivence
0	ttendin death. stor: Aft	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	n	Day rear	Injury	М		res 2□N	No					
<u> </u>	I or Attending after death. Director: After	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of	Injury - At h	ome, farm, st	reet, factory	, office		2	8f. Location (er or Rura	al Route Number,
	ospitel o hours af unerel D ly filled in			<u> </u>											
	I 4 F 0	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	nysician: To the be niner: On the basi and manner	s of examina	owledge, deat ation and/or in	th occurred a evestigation,	at the tim in my or	e, date and pinion, deat	d place, a th occurre	nd due to the ed at the time,	cause(: date ar	s) and ma nd place, a	nner as s and due to	stated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tale of certifier	_ ^			√ 29c	. License	number			29d. Da	ate signed	Month,	Day, Year)
i	MZL		1 Non RC	7	1		0.0	101	4311			6	,/9/	05	
	W-W		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	Print)								
			Dr. William Linth			ngs Dr	. Tar	neyto	own, I	MD 2	21787				
	Sta Regist		31. Date filed (Month, Day, Year)		trar's Sign	ature of the state	/	,							

		•	For State Registrar	State of Maryland		rtment of H		• .	giene	005	21154
	g		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		Philip Foust Bi	erly				June	12,	2005	9:45 A M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death			county of Dea	
			6726 Montell Cour	t		Highland	ł		Но	ward	
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	9. Bir <i>C</i> c	thplace (State or Foreign
	Director		578-24-7987	86	Yrs.			Dec. 5			nsylvania
	and and	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits
	Manyi 1 sho	0	Maryland Howard	III oh 1	ل س م ا						1 ☐ Yes 2 X No
	28a-	Director	10e. Street and Number	Highla	and	10f. Zip Code			10a, Citiza	en of What Co	ountry?
	3e or		6726 Montell Cour	t		20777		1	USA		•
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi	spanic Origin? (Sp	pecify Yes or No		4. Race - Am	
9	after or Ite	Ī	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No		Yes, specify Cuba		Rican, etc.)		Black, Whi	•
Ř O	rel', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:		5	Specify: Whi	lte
2-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation 1 de completed)	6a. Deced	lent's Usual Occupa	ation Juring most of work	king	16b. Kin	d of Business	/Industry
2	ithin De. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of OO NOT use retired,)				
2	lied w lygiei her t		12 17. Father's Name (First, Middle, Last,		Machi	nist	18. Mother's Nam	a //Time haidele			ntractor
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "neturel", or Items 23e or 28a-f show atic event. The Madical Extrait er matthe motified at	Be	Robert Bell Bierl							umame)	
Ĕ	hould d Me mark matic	ပ	19a, Informant's Name/Relationship	_	10b Mailio	g Address (Street a	Pansy Lu			Town State	Zin Codol
<u>⊠</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "neturel; or Items 23e or 28a-1 show entry or other treumatic event. It is Modified at entry or other treumatic event. It is Modified at once.		Edith H. Bierly/w	21 1		Box 266				TOWN, State,	21ρ C0dθ)
ā,	Heal Heal tem		20a. Method of Disposition	20b. Plac		sition (Name of natory or other place	_	Date /4		ation - City or	Town, State
<u>o</u> E	ages ent of it: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Tuernoval iloni State		natory or other place 1 Cremato		/ 1	Odent	on Ma	ryland
altimore,	nit. F artme ortan injur		21. Signature of Funerah Service Licer				•				
ñ	Dep Imp		Bone G LL	FO H MO12	Go 51 Bo	. Name and Addres ing Home	Crematio	n Servi	ce P	0. Bo	x 784 e. MD 21029
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death.	Do not enti	er the mode of dying	g, such as cardiac	or respiratory as	rest,	KSVIII	Approximate Interval Between
	Pnysician		Immediate Cause (Final								Onset and Death
1	/Medical		disease or condition resulting in death)	a.Myocardial Inf Due to (or as a consequer		Lon					Immediate
1	Examiner		0	b							
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	nce of):						
	nd rans	Examiner	that initiated events resulting in death) Last	c.							
Ő	e executana	Ē	resulting in death) Last	Due to (or as a consequen	ice of):						
8760,	icate be executed physician and s the burial-transit	dicai		_ d.							
9	eath certific attending p for use as	0	IF FEMALE:	23c. If yes, outcome of pregnance							
Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal de	ath 3	Ectopic pregnancy Other (specify)			23	3d. Date of de Month	livery Day Year
o	that the de led by the a detached t	Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown	11 3	(Specify)					
Q	that the by deta		Part II. Other significant conditions	contributing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco us	e contribute t	o the cause of death?
ds,	The law requires that the death certifi ate has been signed by the attending i page 2 should be detached for use as	d by	Pulmonary Embolis	sm, Bile duct ob	struc	ction, Pa	cemaker,	1 🗆 🗅	∕es 2X	No 3□P	robably 4 DUnknown
Record	w requir s been si should	iete	Coronary bypass	zuroerv				24a. Was	an	24b. Were a	utopsy findings available
Re	The lav cate has page 2	Completed	outonary bypass t	Jurgery					rmed?	prior to death?	completion of cause of
Vital		o o	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2 No	1 L Yes	s 2□ No
<u>=</u>	S S	0 8	examiner? 1 □ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ EP	VOutpatien	t 3 DOA Othe	or: 4 ☐ Nursing H			Other (Spe	ecify)
J Of		n: T	27. Manner of Death		Bb. Time of Injury		at	28d. Describe t			
jo		atic	1 X Natural 5 ☐ Pending investigation	n	,u.y		Yes 2□No				
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined		e, farm, str	eet, factory, office		28f. Location (S City or Tox		Number or R	ural Route Number,
0	ital o										
	Hosp 4 hou Fune tely fi	edicai	(Check only 2 Medical Exal	nysician: To the best of my knowle miner: On the basis of examination	edge, death and/or inv	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time.	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number		29d, Date	signed (Mani	th, Day, Year)
1	F 3 F 8		In Alm	2							,
4	13	- 5	30. Name and address of person who	completed gause of death (Item 2)	3a) (Type	D1872	D		June	13, 20	105
	(d, 9).		Arthur Schoengolo				Drive T-1	01nev	, MD	20832	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Maistrar's Signatur	0				سبد ر	20002	
	Registr	ar	JUN 1 4 2	2005 Steen D	. A	review					

		-	For State Registrar	State of Marylar		artment of H		Mental Hyg	jiene	**
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last)	n David Bal	ker			2. Date of Dear Month	th Day Year	3 dime of peals 5
	Examin		4a. Facility Name (If not institution, give s Washington Co.			4b. City, Town, or Hager	stown		4c. County of Deat Washin	
	Funeral Director				(last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		2 ⁷ 3, 1939 ^{9. Bird}	thplace (State or Foreign buntry)
	Maryland -f ahow	tor	Usual Residence of Decedent	ngton 10c. Ci	ity, Town or Lo	Hagers	town			10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	al Direc	10e. Street and Number 16937 Shinham	Rd•		10f. Zip Code 217	40	1	0g. Citizen of What Co USA	untry?
920	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-f ahow evant, if a M-dical Ex. vitra f. ual b. maffied at	Completed by Funeral Director	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	ispanic Origin? (n, Mexican, Puel Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specity:	
21215-0036	within 72 ho iene. rthan "natur il e Medical	ompleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired Sembly 1	during most of wo l)	orking	small mo	
ਰ	should be filed and Mentat Hygis la marked othar aumatic evant, II	To Be C	17. Father's Name (First, Middle, Last) Charles	Baker	,		18. Mother's Na Alic	me (First, Middle, e Naill	Maiden Surname) e	
, Mary	and 2 shouralth and Maranth 27 la marente		19a. Informant's Name/Relationship (Ty Margaret Baker		19b. Mailir 1700	ng Address (Street a	and Number or R e Hill	Rd., Hag	r, City or Town, State, 2 gerstown,	MD 21740
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 Ia marked any injury or other traumatic ev once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 D R 1 ☐ Operation 5 ☐ Other (Special)		cemetery, crei	esition (Name of matory or other place y Cemete	ery 6/	1	20c. Location - City or Myersvill	
Balt	permit. Departr Imports any inj		21. Signature of Funer (Service Lice)	COS	25	bonatori 31 E. Ma	S. Inom	pson Fu , Middl	neral Hom etown, MI	ne 21769
	Pnysician		234. Part1. Enter the disease, or compli- shock, or beart failure. List only or Immediate Cause (Final disease or condition	ne cat se o I each line.		er the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a consection). Due to (or as a consection).	quence of):		monie	٦.		
·0,	death certificate be executed e attending physician and id for use as the burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		alhic	liver	cinh	wsis		
68760,	rtificate be ex ng physician s as the buria	Medical	IF FEMALE:	1.						
.O. Box	9 ਦੇ ਮੌ	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery Day Year
<u>α</u>	sign d be	by	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.		bacco use contribute to es 2 □ No 3 □ Pr	
Vital Records,	The ate h	Completed						24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of 2 No
of Vita	Physician: Th this certificate ral director, pa	To Be	1 165 ZE NO	lospital: 1 4 mpatient 2] ER/Outpatier	nt 3□ DOA Othe	er: 4 Nursing	eath <i>(Check only on</i> Home 5 - Reside	ee) ence 6 □Other (Spe	cify)
Division c	e (fe	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	/ at k? Yes 2 □ No		ow injury occurred	
Divi	i itte		4 Homicide determined	28e. Place of Injury - At I building, etc. (Special Control of the	ify)			City or Town		
	To tha Hospital within 24 hours a To tha Funaral I completely filled	ledical	(Check only 2 Medicel Exemi	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	vestigation, in my or	pinion, death occ	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	with To I	Σ	29b. Signature and title of certifier Madhau W	blily		29c. License	2562		9d. Date signed (<i>Monti</i>	,
	5		30. Name and address of person who co			Print)	OSPITAL			
•	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 4 2	32. Priistrar's Sign	ature	Conti				

			For State Registrar	S	tate o	f Maryla		artment of hartificate of		d Mental Hy	rgiene Reg. N2 0 0 !	5 21156
	Physici		1. Decedent's Name (First, Midd	ey An	n Bat	its				2. Date of De Month June		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution 3300 Peachtree	n, give stree				4b. City, Town, o			4c. County of	
	Funeral Director		5. Social Security Number 578–48–6382	6. Sex 1 ☐ M	2 ⊠ F		s. last birthday) 68 Yrs.	If Under 1 Year Months Days		lin. (Month. Di	rth 0	Birthplace (State or Foreign Country) Washington, DC.
	σ		Usual Residence of Decedent 10a. State 10b. County			10c. 0	City, Town or Lo	cation		, aren z	-7, 1737	10d. Inside City Limits
	the Mar 28a-f al	Director	DC . 10e. Street and Number	N/.	A		Wash	ington, I).C.		10g. Citizen of Wha	1 ☑ Yes 2 ☐ No
	s 23a or	ral Di	1451 Cedar Str						20020		United St	tates
036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or Items 23a or 28a-f ahow aumatic event, Ite Marical Examirer in unit by malified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	ried	Was Dece Armed Fo 1 □ Yes If Yes, Giv Year or D	2 🔯 No 18		Was Decedent of h f Yes, specify Cub 1 ☐ Yes 2 2 No	an, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	Black,	American Indian, White, etc. Black
21215-0036	filed within 72 ho Hygiene. other than "natu	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12) 12th	st grade co	on <i>mpleted)</i> College (1	-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of (d)	working	16b. Kind of Busin	ness/Industry
Maryland 2	should be filed and Mental Hygie marked other umatic event, II	To Be Co	17. Father's Name (First, Middle William Henry		s			155150411	18. Mother's N	Name (First, Middle	o, Maiden Sumame)	Government
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	1	19a. Informant's Name/Relation		Print)						per, City or Town, Sta	
altimore, l	Pages 1 and 2 nent of Health int: If item 27 iny or other tra		Anthony Batts 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 □Remo	oval from	State	. Place of Dispo cemetery, crer	reachtre sition (Name of matory or other pla 11 Cemete	ce)	Date 10,2005	MD. 2060 20c. Location - Cit Suitland	ty or Town, State
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service	Licensee	80 i-	1 pi v 8		. Name and Addre	ess of Facility	Pope Fund 5538 Mar Forestvi	eral Homes lboro Pike lle, MD.	20747
E	Ph_sician /Medical		23a. Part). Ener the disease of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	r complicati t only one c	ause on e	ach line.			ng, such as card	the L	arrest,	Approximate Interval Between Onset and Death
	Examiner transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		or as a conse	өциөлсө оі).					T TOWERS
58760,	icate be executed physician and s the burial-transit	dical Ex	resulting in deathy Last	d	Due to	or as a cons	equence of):					
P.O. Box 6	Attending Phyaician: The law requires that the death certific refeath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		1 Live b	come of preg pirth 2 Fe pant at time of pwn	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date o Month	
	w requires that been signed b should be deta	by	Part II. Other significant condit			MAT	01701	ARTHI	LITIS	_ 10	Yes 2□No 3[ute to the cause of death?
Division of Vital Records,	The law recate has been page 2 sho	Completed		H	15+0	v5 5	PUL	MUNAA	7 FM	bo//5 Pa Was auto perf 1 = Yes	ormed? dea	re autopsy findings available or to completion of cause of th? Yes 2 \sum No
r Vita	yaician: Th is certificate director, pag	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 🛣 No	Hosp	oital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ot		Death (Check only g Home 5 Res	one) idence 6 X Other((Specify) Son's
ion oi	Attending Phyaician: The sr death. ector, After this certificate he by the funeral director, page	ertification; T	L _ / tooldont	ng igation	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	f 28c. Inju Wo	ry at rk? Yes 2 □ No	28d. Describe	how injury occurred	(Specify) Sin's
Divis	ital or Atters as after de al Directo	O	4 🗆 Hornicide	nined 4	buildi	ng, etc. (<i>Spe</i>	city)	eet, factory, office		City or To	own, State)	or Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical	one)	i Examiner:	On the b	best of my k asis of exami ner stated.	nowledge, death nation and/or in	vestigation, in my	ppinion, death o	ace, and due to the ccurred at the time	cause(s) and manne, date and place, and	due to the cause(s)
)	3 K	-	29b. Signature and title of certification in the second se	wi	Ale	ellis	, lun	29c. Licen	420°	~	29d. Date signed (A	,
	(8		30. Name and address of person Elliott Perlin	, M.D	. 21	L50 Per	nnsy1vai	Print) nia Ave.	NW, Sui	te 3 - 107	Wash, DC.	1
	Sta Regist		JUN 13 2005	-		legistrar's Sig						

	3		State of Maryland / De	partment of Health and	•	/giene	,		
			Ragistrar 1. Decedent's Name (First, Middle, Last)	Pertificate of Death	2. Date of D	Reg. No 2	105	3. Time of	5.7
	Physici		Ronald L Belt Jr.		June 5	Day	Year	6:15	A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea			ty of Death	0.17	
			Holy Cross Hospital	Wheaton		Montg	gomery		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho. 5.78—8.8—8.9.6.8 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	Months Days Hours Min	. (Month. D	rth ay, Year)	9. Birthpla Countr	ice (State or	r Foreign
	Director		578-88-8968 18 4 2 1 38 Yrs	*	July .	18, 1966	Washi	ngton	DC
	yland		10a. State 10b. County 10c. City, Town of	r Location			10	d. Inside Cit	y Limits
	e Mar	ctor	DC Washing	ton				1 <mark>y</mark> ∑ Yes	2 🗌 No
	vith th	Director	10e. Street and Number	10f. Zip Code		10g. Citizen o	f What Countr	ry?	
	eath v	erai	1847 Good Hope Rd SE #202 11. Marital Status 12. Was Decedent Ever in U.S.	20020	Consider Van or N	United	States		
' O	r Item	by Funeral	1 Never Married 2 Married 1 Tyes 257 No	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 	to Rican, etc.)	0- 14. Bi	ack, White, el	tc.	
93	ral', o	by	3₺ Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 21 No Specify:		Spec	ity: Blac	k	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Mickel Examiner must be mailfied all	Completed	15. Decedent's Education 16a. Di (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of wo le. DO NOT use retired)	rking	16b. Kind of	Business/Indu	stry	
12	withir ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) ender		Privat			
<u>0</u>	Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)		me (First, Middle				
/lar	uld be Wenta Irked Itic ev	ToB	Ronald L Belt Sr.	Vasteen	E Arr	ington			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Modeal Examinat must be notified at 90ce.			ailing Address (Street and Number or R				Code)	
e)	1 and Health em 27 ther t			2 Stoney Meadow La: sposition (Name of	ne Sulti		20/46 - City or Tow	n Ctata	
Baltimore,	ages ant of it it: If its y or o		Cometery,	crematory or other place) ction Cemetery Jun					
Ħ.	nit. Partme	1	21. In pay of Funeral Service Licensee	Alexander 5. Fapility			ILOH PAL	,	_
m	per mp guy	1	Meloria Max aus	2617 Penn Ave SE			0020		
			25a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory a	arrest,		Approximate nterval Betw	veen
H	Pnysician	ë y	Immediate Cause (Final disease or condition a. AIDS				- 1	Onset and D	eath
	/Medical Examiner		resulting in death) Due to (or as a consequence of):						
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
	cuted od ransit	Examiner	that initiated events C.				4.		
760,	rate be executed only sician and the burial-transit		resulting in death) Last Due to (or as a consequence of):						
ထ	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical	d						
Вох 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. D	ate of delivery	,	
	death	sicia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					ear
Q.	that the de led by the a detached f	Phy	3 Ouklowii		00. 0.4				
ds,	eg Ped	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		tobacco use coi Yes 2 No			
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Records,	The lay ate has bage 2	Completed	Ψ,		auto perf	psy ormed?	. Were autops prior to comp death?	oletion of ca	use of
ta		a)	25. Was case referred to medical	26. Place of De	1 ☐ Yes ath (Check only		1 ☐ Yes 2	∐ No	
>	Physical this ce al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Other: 4 Nursing			ther (Specify)		
Division of Vital	ding Ph. h. After thi funeral		27. Manner of Death 1 Natural 5 Pending	e of 28c. Injury at Work?		how injury occu			
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<u>></u>		Certification:	4 Homicide determined building, etc. (Specify)	Street, factory, office		wп, State)	iber of Hurar r	100t 0 IADIID	97,
	o the Hospital or ithin 24 hours afte o the Funeral Dir ompletely filled in	edicai C	29a. Certifier Check only (Check only 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place	e, and due to the	cause(s) and m	nanner as stat	ed.	
	To the H within 24 To the F complete	Medi	one) 29b. Signature and fille Acertifier and manner stated.	29c. License number	arred at the time,				
	P M C U		East. Signature and this order this	D55522		29d. Date sign			
			30. Name and address of person who completed cause of death (Item 23a) (Tv				, 2005		
	ياق		30. Name and address of person who completed cause of death (Item 23a) (Ty Dr. Gerald Roberts MD 1500 Forest	Glen Rd Silver Spr	ing MD 2	0910			
	Sta Registr		31 Date filed (Month, Day Year) JUN 1 3 2005						

			For State Registrar	State of Marylan		rtment of H		-	iene 2005	21158
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	IRRELL				2. Date of Dear Month		3. Time of Death 5 6-40 AM
	Examin Funeral Director		4a. Facility Name (If not institution, give s HOLY CROSS REHA 5. Social Security Number 6. Sex	AB AND NURSI		2 0-	Location of Death NSVILL If Under 24 Hrs. Hours Min.		4c. County of Dea	th
	faryland l ehow	ŏ	Usual Residence of Decedent 10a. State 10b. County MD Howard		, Town or Loc	eation				10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	or 28a-	Director	10e. Street and Number	pay.	COII	10f. Zip Code		1	0g. Citizen of What Co	ountry?
036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health end Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f ehow other traumatic event, the Medical Examiner must be multified at	Completed by Funeral	4940 Ten Oak Rd 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	lf	21036 Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2☑ No	ispanic Origin? (Spein, Mexican, Puerto F	cify Yes or No-	14. Race - Ame Black, White Specify: Black	erican Indian, te, etc.
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vent, Ine Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4or 5+)	16a. Deced (Give i life. D		during most of working) ess Desig	ner	16b. Kind of Business Private	/Industry
land	ould be file Mental Hy wrked oth	To Be (17. Father's Name (First, Middle, Last) James Richards				18. Mother's Name Pattie Je		Maiden Surname)	
Mary	nd 2 should be lith end Mental 27 is marked (r traumatic ev		19a. Informant's Name/Relationship (Ty.) Gereal D. McCray/C						City or Town, State,	
aitimore,	permit. Pages 1 and 2 Department of Health e Important: If item 27 it any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b. P	lace of Disposemetery, crem	ition (Name of atory or other plac itan Crem	6-7-0	ate	20c. Location - City or 1exandria	
Bait	permit. Depart Import any inj		Strong of Euneral Service License	Dani	J A2.	Name and Addres 17 Penn	S. Pope F Ave SE Wa	uneral shingto	Home n DC 20020	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a Our as a consequence of the consequence o	car	1	g, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).						
.O. Box 68	the death certifi y the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	es De pa	þ	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the un	derlying cause give	en in Part I.		es 2 □ No 3 □ Pt	_
Il Records,	The ate h page	Completed						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
ion of Vital	Attending Physician: The death. ector: After his certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at 2	le 5 ☐ Reside	e) ince 6 Other (Spe w injury occurred	cify)
Division	al or Attend after death 7 Director: d in by the f	ertification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office	2	8f. Location (St City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital or At within 24 hours after or the Funerel Direct completely filled in by	edical C	29a. Certifying Physical Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the ca d at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	Within V Complete	Me	29b. Signature and title of certifier			29c. License	o 5 4566		9d. Date signed (Mont	h, Day, Year)
	9		30. Name and address of per per o co			Print)				12 5
	Sta 'Registr		31. Date filed (Month, Day, Year) JUN 13 2005	32. Registrar's Signa	ture	zu roza	Sue 11 250	, , , ,	10 N, MI) L	1216

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 0 0 5 Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** hester Ra /Medical 4a. Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 His Social Security Number Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, 220-26-9059 1 M 202 F Months Days Hours Director Maryland June Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ahow other traumatic event, if a Mudical Examiner is ust be notified at Dorcheste 1 Ves 2 No Director ambrid 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 645 Street 9 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 12 Widowed 4 □ Divorced Black "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) la marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. tome maker to Me ノWN 13 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental <u>Jaunders</u> 1150n trances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 ia any injury or other trau once. Cambridge Maryland 21613
Date 20 Town, State 45 R : cKySter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 05 6/17/ * 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery Hurlock, Marylano 21. Signature of Funeral Service Licensee Formula C. Henry Funeral Home, P. A.

13a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such mardiac or respiratory arrest,

Approximate structure. List only one cause on each line. 22. Name and Address of Facility Home, P.A. Approximate Interval Between Onset and Death Immediate Cause (Final ARIZEST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner DETLY ON IT 3 The law requires that the death certificate be executed signed by the attending physician and d be detached tor use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 SNo 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ROUEL 1 ☐ Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) \(2 \text{\text{No}} \) No 24a. Was an has autopsy performed? this certificate 1 Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? atter death. 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funeral L

State

29b. Signature a

certifie

Registrar

ame and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

026040

ST. CAUBRADE und

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9 Month **Physician** Slade Deville Cutter 2005 5:30 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Health Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | No V . 1, 1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 152 M 2□F 93 224-52-3213 Yrs. Director Illinois Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Mudical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryl and Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 6102 River Crescent Drive 21401 Items 23a United States death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White δ Specify 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Watts Cyrus Esther Sundeen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other tratence. Ruth M. Cutter / Spouse 6102 River Crescent Drive Annapolis MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 6/12/2005 Baltimore, Maryland Baltimore Crematory 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licersee 147 Duke of Gloucester St. Annapolis, MD 21401 11 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician DISEASE ARKINSON'S disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last ng physician ar as the burial-to Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Year Month 4☐Pregnant at time of death Day 5 Other (specify) P.O. I the 9 Unknown 9 Unknown Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by EFFUSION. WINE INFECTION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - Athome, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M Wobbs w 1)24768 10-9.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

William Dabbs M.D.

T3 2005

Arnold, Maryland 21012

277 Peninsula Farm Road

			1 - For State Registrar		of Maryla				ealth a	ind M	lental H		20(15	2116
ı	Physici /Medic		Decedent's Name (First, Mid CLARA	die, Last) ANN	CI	MBA				,	2. Date of D Month JUNE	Death Da	20	Year 005	3. Time of Dea 3:44 I
	Examir		4a. Facility Name (If not instituti CORSICA HILI				C	ENTRI	Location o	Ξ		40	QUE	of Death	NNE
	Funeral Director		5. Social Security Number 208-22-8272 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yr:	s. last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of B (Month, L AUG. 5	Dav. Year	28 F	9. Birthpl Coun PENNS	lace (State or Fo. try) YLVANIA
	th the Maryland or 28a-f show e notified at	Director	10a. State 10b. Coun FL CLAY 10e. Street and Number			REEN CO	VE S	p Code					itizen of W		0d. Inside City Li 1X Yes 2 try?
-0036	72 hours after death with the Maryland natural, or items 23a or 28a-1 show dical Exertinst must be notified at	by Funeral	411 WALNUT S 11. Marital Status 1 Never Married 2 M Ma 3 Widowed 4 Divorce	12. Was De	2 MNo Bive		1 🗆 Yes	2 X No	spanic Orig n, Mexican Specify:	gin? (Spi , Puerto	ecify Yes or N Rican, etc.)	10-	Specify:	WH	etc.
Maryland 21215-0036	be filed within 72 tal Hygiene. d other than "na event, the Medic	Completed		cest grade completed College -0	(1-4or 5+)	(Give life.	kind of w	ork done d use retired	luring most)		ing e (First, Middl	07	VIN HC	ME	iustry
arylan	should be ind Mental i marked c	To Be	JOHN SINAR 19a. Informant's Name/Relation						And Numbe	NNA	GAZDA	ber, City	or Town, S		Code)
Baltimore, M	ss 1 and of Health item 27 r other t		MICHAEL CIMI 20a. Method of Disposition 15 Gurial 2 ☐ Crematior 4 ☐ Donation 5 ☐ Other	n 3 Removal from	n State	P.O. Place of Dispondernetery, cree ESTERFI	sition (Na natory or	me of other place	e)	(LLE, M	20c. L	617 ocation - 0		
Balti	permit. Page Department Important: ff any injury or once.		21. Signature of Funeral Service		Han	- FF	Name a	nd Addres	s of Facility	EIN		AM FI	UNERA	L HO	ME, P.A.
18760,	death certificate be executed e attending physician and of or use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	ab	oach line.	five de de de de de de de de de de de de de	leed My	fast.	ure		, iospitatory			<i>p</i> .	Approximate Interval Between Onset and Death Months
O. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live	utcome of pregr birth 2 Fel gnant at time of nown	taldeath 3□	Ectopic p						23d. Date Mon		ry Day Year
7	w requires that the been signed by th should be detache	þ	Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying	cause give	n in Part I.			tobacco		bute to the	cause of death
or vital Records,	The law ate has b page 2 sl	Completed									24a. Wa: auto perf 1 □ Yes		pr de	rior to com eath?	sy findings availa apletion of cause 2 No
N VIL	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2				E 4 Nur		n <i>(Ch</i> eck only me 5 ☐ Res		6 Othe	r (Specify))
Division	Attending ir death. ector: After by the fune	Certification:	3 Suicide 6 Could	tigation d not be mined 28e. Place	of Injury orth, Day Year) pe of Injury - At I	28b. Time of Injury	М		at ? ′es 2 □ N	lo	28d. Describe	(Street ar	nd Numbe		Route Number,
5	To the Hospital or within 24 hours after to the Funeral Dir completely filled in I	edical Cert	29a. Certifier Check only 2 Medica	ing Physician: To the	ding, etc. (Spec	owledge, death	occurred	at the tim	e, date and	place, a	and due to the	cause(s	and man	ner as sta	ited.
	To the within 2 To the 1 Complet	Med	29b. Signature and title of certifi	and ma	nner stated.		29	c. License		33			te signed		
	Sta Registr	-	30. Name and address of perso MICHAEL D. CR 31. Date filed (Month, Day, Yea	OWLEY, M.		O DUTCH	MAN'		IE, EA	STO	N, MD	21601	L		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) DRUMMOND Month Day **Physician** WATKINS RUTH 0500M June 2005 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL (ENTER SAL15BURY DEERS HEAD WICOMICO 8. Date of Birth
(Month, Day, Year)
July 2, 1923 West Virginia If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗹 F 578-32-7327 81 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Wicomico Salisbury 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 351 Deers Head Hospital Road 21801 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗙 No ρ Specify: white 3 Widowed 4 □ Divorced Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) 11 secretary real estate f Health and Mental Hygi item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be _ Walter E. Watkins Opal Ballah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Jackson daughter P. O. Box 414, Vienna, MD 21869 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit Pages 1 Department of H Important: If ite any in ury or ot 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Jones Cemetery 6/16/05 Fairmont, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. once. Bu 700 Locust St., Cambridge, MD D/Velin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** 14 HRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERSISTENT VEGETATIVE STATE Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner RICHT INTRACEREBAL HEMORRHAGE The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie a q 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nulawy MD CMD D33905 June 12, 2005 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) VIRGINIA A. Dulany MD CMD PO BOX 2018 SAL15BURY Md 21802-2018 32. Regitrar's Signature 31. Date filed (Month, Day State Registrar

1	,		1 - State Unpend Item	- '	f Maryland / De per me 6844 C						21162
			Decedent's Name (First, Middle,					2. Date of D	eath	000	3. Time of Death
	Physici		Jay Richard Dulen	ıba				June	O9	2005	8:22 A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)	4b. City, To	own, or Location of			ounty of Death	0.22 11
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3	Funeral		5. Social Security Number	S. Sex	7. Age (In yrs. last birthda	y) If Under 1 Months [Year If Under Days Hours	24 Hrs. 8. Date of Bi Min. (Month, D			place (State or Foreign
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and	0 0 0	Be	17. Father's Name (First, Middle, La	ist)			18. Mothe	er's Name (First, Middle	, Maiden Su	mame)	
ž	d Mental marked o	P_	Mitchell A. Dulemba		40, 11			h E. Duggan			
Maryland	ls ar		19a. Informant's Name/Relationshi		19b. Ma	iling Address (S	Street and Numbe	er or Rural Route Numb	er, City or T	own, State, Zip	Code)
	1 an Teal	1 10	Marcelina B. Dulemb 20a Method of Disposition	a/Wife	4592 20b. Place of Dis			lifornia, MD Date	20619	tion - City or To	State
Baltimore,	e = t 6		1 X Burial 2 ☐ Cremation 3		State cemetery, c	ematory or other	er place)				
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		Doroth	y L. Diehl						JUNE	14 Day	2005	1358	М
nine	r	4a. Facility Name (If not institution, give MEMORIAL HOSPTIA					Location of	of Death			County of Death		
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i		170 Old Deal Road				552				USA		nuy:	
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		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the d								.5552_	Approximate Interval Between	
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13:		5	GENESIS ELD i. Social Security Number	ERCAR 6. S		RNA PARK		SEVE If Under		PARK If Under	24 Hrs.	8. Date of Bir		NE AR		or Foreign
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Baltimore, permit. Pages 1 a Department of He	any inju once.		21. Sign to of Funeral S	arvice Ligh	nsee	the	22 F1	2. Name <i>a</i> n	d Addres	ss of Facilit	BETN	& NEWN	IAM FIIN	IERAT.		P.A.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1-	For State Registrar	
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Physician /Medical Examiner

Funeral

filed within 72 hours after deeth with the Maryland r than "natural", or Iteme 23a or 28e-f show the Medical Examinar must be notified at is marked other permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: if Item 27 is marked oth any linjury or other treumatic event 2008.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed physicien end s the burial-transit attending I signed by the a d be detached f been : this certificate Atter thi i Director: A d in by the tu within 24 hours a

Division of Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death June 9, Thelma L. Dempsey 2005 6:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arundel 7. Age (In yrs. last birthday)

R2 Yrs. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | 8-20-1921 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1 □ M 2 X F Director 577-12-5768 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXIo Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Mariner Ct. 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: White þ 3℃Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Rowe Peggy Jacobs 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Shore Dr., Edgewater, MD 21037 Shirley J. Downey/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Cemetery 6–11–05 Davidsonville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses Mould 2973 Solomons Island Rd. Edgewater, MD 21037 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Co Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Consessed or Injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 5 e ps. 5 Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 ₽No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\to \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending M 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6/09/05 D 26373 Gree-WUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenfield, uns 139 old Solar In/ R.S 31. Date filed (Month, Day, Year) 2005 32. Registrar's Signature

State Registrar

Amend item#23aPII 25 perMi G846, 8/11/05 ITE Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** Month Jose Vicente Del Cid 2,_ June 9:25 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
July 19,1960 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F 44 Director 214-21-3528 Yrs. El Salvador Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director Prince Georges Maryland Hyattsville the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8512 - 14th Place 20783 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2X No Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) McFall & Berry Land-Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) scape Management, Inc. 8th grade Landscaping Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental i Vicente Del Cid 2 Maria Lidia Chicas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and important: If itam 27 Is n any injury or other traun Vicente Del Cid (Father) 5906 Spruce Run Court; Centreville, Virginia 20121 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State
Agua Caliente, La Union June 17, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mance Dulce Cementerio El Salvador 2005 21. Signature of Funeral Solvice Licensee 22. Name and Address of Facility
Santa Cruz Funerarios Servicios
600 Kennedy Street, N.W.; Washington, D.C. 20011 Dandolps 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory agrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER the attending physicien and hed for use as the burial-translt Intestinal Obstruction that initiated events resulting in death) Last Due to (or as a consequence of): 68760 certificate be Physician/Medical **Enterocolitis** Box IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9□ Unknown 9 Unknown þ sete has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Abdominal adhesions and intraperitoneal hernias Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2X No 1 Yes 2 No After this certification, 25. Was case referred to medical Be 26. Place of Death (Check only one) Yes Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗍 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 4000C D0008513 Icellar is June 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Restrego', M.D.; 8955 Edmonston Road; Suite I; Greenbelt, Maryland 20770 Gustavo 32. Reclatrar's Signature JUN 1 3 2005 ear) State Registrar

Late

Emmanuel, Ignatius Gunam
Baltimore. Marvland 21215-0036

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		30. Name and add s of person of	completed cause of de	eath (Item 23	3a) (Type, Prin	AIN STR	EET SO	IS VITE 301	, LA	UKEL, A	10 to	207
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yee **Physician** MARTHA SALLY ESHER JUNE 3 2005 12:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1056 HAMPTON DRIVE CROWNSVILLE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F JUN. Director 136-36-0097 59 7, 1945 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It has the 23a or 28a-1 show other traumatic event, the 7 health at 6 other traumatic event, the Medical Examination in the Examination of the confilter at 6 other traumatic event, the Medical Examination in the Confilter at 1 Yes 2 X No Directo ANNE ARUNDEL CROWNSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1056 HAMPTON DRIVE 21032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ▼ Married Maryland 21215-0036 Completed by If Yes, Give Year or Dates: 1 Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY FEDERAL RESERVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental JOSEPH F. BARNETT, SR. FLORENCE MARGARET MCGRAIL ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a: If Item 27 is 1056 HAMPTON DRIVE, CROWNSVILLE, MD JOHN W. ESHER/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name o. Date 20c. Location - City or Town, State CROWNSVILLE VETERANS CEMETERY ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Importent: I any injury o ¹ 4 □ Donation 5 □ Other (Specify) 06/06/2005 CROWNSVILLE, MD 21. Signal Te / Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition all **Physician** small 8/04 resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑No 24a. Was an page 2 autopsy 11160 ? 2 ⊠No 1 ☐ Yes Be 25. Was case referred to medical examiner? derector 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ŏ Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai

State Registrar

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Baltimore,

Box 68760,

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Records,

Division of Vital

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

ance

Year) KUTKOWIEK 1315 Annapolis Rd

29d. Date signed (Month, Day, Year)

and manner stated

MD

32. Fi sistrar's Signature

30. Name a vaddress of person completed cause of death (Item 23a) (Type, Print)

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner PASCK, MI MONTGOMERY AKOMA 10 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2X F Hours Director 83 577-22-2452 23, 1921 Pennsylvania Oct. Usuel Residence of Decedent Pages 1 and 2 should be illed within 72 hours after death with the Maryland nent of Heatth and Mental Hyglene. ent of Heatth and Mental Hyglene. ent: if item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Example must be notified at Director TY Yes 2 □ No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1608 Amherst Road 20783 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 27 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Private Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph DeMarco Grace Packard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Burke, Cousin 12349 Point View Road, Bishopville, Maryland 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent; if it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation , 5 □ Other (Specify) 06/13/2005 Gate of Heaven Silver Spring, MD 21. Signature of Eungral Service Leensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, Maryland 23a. Part1. Enter the disease, or it implications that caused the shock, or heart failure. List only one cause on each line. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 3 No 1 Tyes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 12 patient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Director: After 5 Pending investigation 1/ Natural death. 2 🗌 No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 29a, Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D61307 06/09/0 Pe. Print) CANNOLL AVE, TAXOMA AME 30. Tame and address of person who completed MEKON 31. Date filed (Month, Day, Year) State **JUN 13** Registrar

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er de Item	Funeral Director	11. Marital Status	Armed Fore	dent Ever in U.S. 1 ces?	Was Decedent of If Yes, specify Cu	Hispanic Origin ban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	- 14. Race Black,	- American Indian, , White, etc.
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinational be notified at	by F	1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	If Yes Give		1 ☐ Yes 2XX N	o Specify:		Specify:	rihita
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Richard Wayne Fortner June 5. 2005 3:02 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1580 Dalymple Road Sunderland Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours 1**⊠** M 2□ F 62 Yrs. 213-40-8444 Indiana Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. Counts ral', or Itams 23a or 28a-f show Examiner aust be notified at 1 ☐ Yes 2 ☑ No Director MD Calvert Sunderland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1580 Dalymple Road 20689 USA Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 □ Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Tattoo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill treent of Heelth and Mental H tent: If Item 27 is marked ott Helen Elizabeth McCoy Forrest Edward Fortner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a importent: If Item 27 is any injury or other trains once. Dorothy Fortner (Wife) 1580 Dalymple Road Sunderland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 9 😰 Burial 2 🗆 Cremation 3 🗆 Removal from State 2005 Southern Mem. Grdns. Dunkirk, MD 20736 * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licensee J. Gary Coff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 1/2 Yrs Physician Malignant Lymphoma /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause ID sease or injury that initiated events Due to (or as a consequence of): Examine nding physicien and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 F Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No Yes Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 5 Pending death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43361 June 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ID Robert S. Siegel, MD2150 Penna. Avenue NW Washington, DC 32. Registras Signature State 2005▶ alour, to Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FRIZZELL Month Day O'4 **Physician** HAZEL J 3:18 PM 2005 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CARROLL TANETTOWN LORIEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. August 22, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral 1□M 2√F Months Maryland 218-24-9086 76 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State r than "natural", or itams 23a or 28a-f show tre Medical Examinar must be notified at 1 Yes 2 No Director Carroll Maryland Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 178 Lincoln Road 21157 United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes XX No If Yes, Give Year or Dates: Never Married 2☐ Married 1 ☐ Yes 2 No Specify: Specify: White څ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I othar than " Elementary/Secondary (0-12) College (1-4or 5+) Cashier Drug Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be find and Mental Pris marked of permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked cany injury or other traumatic eve 20x8. (Unknown) Margaret Eyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Jenkins/Sister 429 Barlow-Two Taverns Road, Gettysburg, PA 17325 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 6/8/2005 Burial 2 ☐ Cremation 3 ☐ Removal from State Deer Park Methodist Cemetery Westminster, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death mediate Cause (Final diameter or condition resulting in death) CONGESTIVE FAILURE Physician HEART 2 WEEKS /Medical Due to (or as a consequence of): Examiner YEARS FAILURG RENAL HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🛣 No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 1 ☐ Yes ☐Yes 2☐No 2 X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 After this of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funaral Director: A completely filled in by the fu investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1📤 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the } 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie WIL D0014317

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) JUN 0-8 2005

ONE

KINGS

32. Registrar's Signature

TANEY TOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE

State

Registrar

WILLIAM R. LINTHICOM

MARYLAND

O5-O4160 AMBER GLENN WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 45,28f per meo g844 6-27-05 vt.

		4	1 - State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death	Reg.	
	Physicia		1. Decedent's Name (First, Middle, Last) AMBER SUE GLENN		2. Date of Death Month JUNE 18.	Day Year 1:10 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, 1941 GTV Itin Coeath		4c. County of Death
	Funeral		RT 24 & ST MARY'S ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	HARFORD CO 9. Birthplace (State or Foreign Country)
٠.	Director		163-76-3082 1	World Days Hours Will.	12/9/1994	Pennsylvania
	death with the Maryland ms 23e or 28e-f show rinust be notified at	5	10a. State 10b. County 10c. City, Town or U PA York Delta	ocation		10d. Inside City Limits 1
	ith the N or 28e-f	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	eath wi	eral	PO Box 145; 316 Baptist Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Historic Origin? (Soc	ocity Vas or No-	USA 14. Race - American Indian,
36	or ite	by Fun	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16b	. Kind of Business/Industry
2			4 Stud	dent	(First, Middle, Maid	den Sumame)
/lanc	Q 2 2 9	To Be	Mitchell B. Glenn		M. Atki	•
Maryland	id 2 sho Ith and I 27 Is ma treuma			ing Address (Street and Number or Rura $$		ty or Town, State, Zip Code)
Baltimore,	ages 1 and 2 should ent of Health and Men nt: If item 27 Is marke y or other treumatic	i	20a. Method of Disposition 20b. Place of Disposition cemetery, cre		Date 20c	Location - City or Town, State Delta, PA
Baltin	permit. Pages Department of Importent: If i any injury or o		21. Signatur of Funeral Service Acensee	2. Name and Address of Facility Plains Funeral Home, Inc.		
r			23a. Part1. Enter the disease, or complications that caused the death. Do not enchock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
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f Vit	ys dii	To Be	25. Was case referred to medical examiner? 1 XYes 2 \(\Delta \) No Hospital: 1 \(\Delta \) Inpatient 2 \(\Delta \) ER/Outpatie	26. Place of Death		6 XOther (Specify) SCENE
	ng After		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury 28b. Time (Month, Day Year)	Work?	28d. Describe how in	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide Homicide Suicide	28f. Location (Street City or Town, St	and Number or Rural Part 11e ate) Many Rd, Farm Charles	
_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, dea 2☆ Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, and	and due to the cause	e(s) and manner as stated.
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number OCME		Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type		JU	JNE 19, 2005
_			Tasha Z Greenberg M.D.	111 Penn Street	Baltimore	e, Maryland 21201
	Sta Registr		31. Date filed (Month Pay, 29ar) 33 Regis rar's Signature	all D		

			1 - For State Registrar	State of N	Naryland / Depa Ce	artment of F			iene 2005	5 21176
	Physic /Medi		Decedent's Name (First, Middle, Anna Bernice					2. Date of Deat Month June	3	3. Time of Death
No.	Exami		4a. Facility Name (If not institution, 305 Locust The	•	r)	4b. City, Town, o	r Location of Dea		4c. County of D	
	Funeral Director		5. Social Security Number 229–38–4584		Age (In yrs. last birthday) 80 Yrs.		If Under 24 Hr Hours Mir	s. 8. Date of Birth		Birthplace (State or Foreign Country) WV
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Anne A	rundel	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the I 3a or 28a-	Funeral Director	10e. Street and Number 305 Locust Thor	n Court		10f. Zip Code	108	10	Og. Citizen of What	
036	be filed within 72 hours after death with the Maryland tal Hygiene. ud other than "neture!, or Items 23a or 28a-f show event, the Medical Examinational by routiled at	by	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Forces	s? X No		ispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - A	merican Indian, /hite, etc.
21215-0036	filed within 72 ho Hygiene. xther than "netur ent, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 4	(Give life.	dent's Usual Occupi kind of work done of DO NOT use retired School Tea	during most of wo	orking	16b. Kind of Busine	,
Maryland 2		To Be C	17. Father's Name (First, Middle, L Unavailable	ast)			18. Mother's Na	me (First, Middle, Mavailable	faiden Surname)	
re, Mary	t and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationshi Michael Gutin/ 20a. Method of Disposition	Son	305 20b. Place of Dispo	Locust !	Thorn Co	the state of the s		e, MD 21108
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		1 Burial 2 XCremation 3 4 Donation 5 Other (Special Service Li	ecify)	Metro Cr		2	2005	Baltimore	e, MD
80	80 5 5 8		23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause	ed the death. Do not enti	Name and Address ATTANCO (195 Gov. 1	Ritchie g, such as cardia	Hwy. Sev	erna Park	K Funeral House K, MD 21146 Approximate Interval Between
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Division of Vital Records,	ding Phys	ation; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ent 2 ER/Outpatient ury 28b. Time of Injury	28c. Injury Work	r. 4 □ Nursing H at	ath (Check only one) dome 5 Residen 28d. Describe how		recify)
DIX.	ital or Attendurs after deathrel Director:	Certification;	3 Suicide 6 Could not determine	ed 28e. Place of In building, e	jury - At home, farm, stre tc. <i>(Specify)</i>			City or Town,	State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	one)	Physician: To the best aminer: On the basis of and manner st	of my knowledge, death of examination and/or invested.	estigation, in my opi	inion, death occu	, and due to the cau irred at the time, date	se(s) and manner as and place, and du	as stated. ue to the cause(s)
•	T wit		29b. Signature and title of certifier		izian		695°	290	Date signed (Mor	oth, Day, Year)
	Sta		30. Name and address of person when Nucleur Age 31. Date filed (Month, Day, Year)	ijelu 80	death (Item 23a) (Type, E 94 Edwin K ar's Signature	aynor Bl	vd Ruite	A Pasa	adena N	10 21172
	Registra		JUN 13	2005	we DE A	mark!				

Amended Item 20b per F.D. 06/10/2005 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 80 2່ດໍ່ດື້5 June 7:00 a M Phoebe Roop Goldsboro /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Westminster 339 Stoner Avenue 8. Date of Birth (Month, Oay, Year If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F Dec 14, Yrs. 217-16-1122 98 1906 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County Itam 27 is marked other than "natural", or Itams 23s or 28s-1 show other traumatic event, to the discussion must be notified at 1 Yes 2 No Director Maryland Carroll Westminster 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with 339 Stoner Ave 21157 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Social Worker Allegany County, MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked o Sallie Geiman Joel I. Roop 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Itam 27 is any Injury or other tratence. Elizabeth Roop Channell Sister 339 Stoner Ave. Westminster, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Potomac "Mem. or Gardens 15 Surial 2 ☐ Cremation 3 ARemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Potomas Mem. Gardens 6/11/05 Keyser, West Virginia 21. Signature of Funeral Service Licenses Britts funerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death SEVERE ADRTIC STEFOSIC Immediate Cause (Final disease or condition resulting in death) **Physician** 6 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Jo 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28d. Di scribe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation s after de. 1 □ Yes 2 □ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31660 06/09/2005 Talvis Ty, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 291 STONER AVENUE WESTMINSTER MAKULAND THOMAS K. GALVIN III. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Blow & Speck Registrar

			For State Registrar		State	of Man	-	•	tment of F			-	•	000	, p	0 1 1
			Decedent's Name ((First, Middle, La	est)				modito or i	Douth		2. Date of De	Reg. N	°. Z U U	9	3. Time of Death
	Physicia		Harry Cob	h Green								June 8		ay Y∈ 005	ar	18:25 p ^M
	/Medic Examin		4a. Facility Name (If r		e street and n	umber)			4b. City, Town, o	r Location				c. County of [Death	
			Chesterto	wn Nurs	ing & R	ehabi	ilitati	on	Chester	town				Kent	:	
	Funeral Director		5. Social Security Nur 092-03-92		Sex 1.2XM 2.□F	7. Age (I	In yrs. last birth	rday)_ rs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month Da April	th v Yea 2,1	905	Birthpl Count P	lece (State or Foreign try) A
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with	9 01	늅	4673 East		le Talor	ad			10f. Zip Code 216	661			USA	itizen of Wha	t Coun	Iry r
death	na 23	Funeral	11. Marital Status	Lein NEC	12. Was De	cedent Eve	er in U.S.	13. W	as Decedent of H Yes, specify Cuba		igin? (Spe			14. Race - /	America	an Indian,
hours after death with the Maryland	of Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event. It's Medical Examinar must be notified at	by	1 ☐ Never Married 3 🛣 Widowed 4	_	Armed F 1 X Yes If Yes, G Year or	2 □ No Sive			Yes, specify Cuba □ Yes 2 🎛 No	an, Mexical Specify:		Rican, etc.)		Black, \ Specify:		
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should be filed within 72	and Mental Hygiene. Is marked other than aumatic event, the Me	o Be	17. Father's Name (F						:			(First, Middle) May Het		in Sumame)		
shoul	md Me	은	19a. Informant's Nam	ne/Relationship	(Type, Print)		19b.	Mailing	Address (Street					or Town, Sta	te, Zip	Code)
and 2	alth a		Julie St	ephens/d	laughte	r	P.	0. 3	Box 353,	Rock	t Hal	1, MD 2	2166	51		
Pages 1 a	Department of Health Important: If Item 27 i any injury or other tra 90008.		20a. Method of Dispo 1 Durial 2 4 Donation 5	Cremation 3		n State			tion (Name of atory or other place t Cemete			3,2005		Location - City	•	wn, State
permit. F	Departming importar any injur		21. Signature of Fund		7	10		22.	Name and Addre	ss of Facili	ity					Home o P.A
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Ph	ysician		Immediate Cause (F disease or condition	inal	one cause on	wach line.	terre	hea	It for	leíre)					Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certifi	signed by the attending d be detached for use as	Physician/Me	23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	nonths?		birth 2 [gnant at tim	pregnancy □ Fetal death ne of death		ctopic pregnancy Other (specify) _	4				23d. Date of Month		ry Day Year
thatt	ed by		Part II. Other signific	ant conditions	contributing to	death but r	not resulting in	the und	derlying cause giv	en in Part	l.	23e. Did	tobacco	use contribu	te to th	e cause of death?
equires	been sign should be	ted by										12	Yes	2□No 3[] Proba	ably 4 □Unknown
The law	ate has be page 2 sh	Completed										24a. Was auto perfe 1 ☐ Yes		prior	r to con	osy findings available inpletion of cause of
V ILC	certificate rector, pag	Be	25. Was case reterre examiner?		Hospital:				0+		e of Death	(Check only	one)			
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ital	rs afte	Certification:	4 Homicide		Duli	ding, etc. (City or To				
he Hosp	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only 2 one)	Certifying P	miner: On the	he best of a basis of ex unner state	xamination and	death Vor inve	occurred at the tirestigation, in my c	me, date ai opinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(, date a	s) and manne nd place, and	er as sta due to	ated. the cause(s)
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			30. Name and address	32 (H)	MERL	M	129	S	VEZN K	کی لات	निर	T Ct	103	STEMY!	2	n, hos
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		1 - For State Registrar	State of Mary		artment of I				. 01170
		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	g. No.2005 Day Year	OF LINES OF DOMES
Physic /Med		Peggy Willey	Hurley				June	9 2005	
Exam	ner	4a. Facility Name (If not institution, give	· ·			or Location of Dea	th	4c. County of Dea	ath
		Dorchester Gene 5. Social Security Number 6. Se		yrs. last birthday)	+	ridge	S R Data of Righ	Dorche	
Funera Directo		215–26–5958	TH OFFE	73 Yrs.	Months Days			Year) 1931 Ma	nthplace (State or Foreign ountry)
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003 hours	b b	3 XWidowed 4 □ Divorced	Year or Dates:						white
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Maryland 21215-0036 2 should be filed within 72 hours after deal and Mental Hygiene. is marked other then "neturel", or Items: reumatic event, If a Michal Examinet re	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	laiden Sumame)	
Vlai	10	Calvert Willey				Virg	inia Mills	}	
Baltimore, Maryland 21215-0036 Dependi. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show more in injury or other treumatic event, Ite Medical Examinational Pages 1.	1	19a. Informant's Name/Relationship (T)		1			Pural Route Number,		Zip Code)
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nit. Partme	47	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens					Thomas Fun	Cambridge eral Home	P.A.
Ball permi Depar Impo	4 15	Brink B	>				Cambridge,		
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ords, P.O equires that the sen signed by th ould be detache	by Ph	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
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Record e law requ has been ge 2 shouk	plet						24a. Was an	24b. Were a	utopsy findings available completion of cause of
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f Vital Re ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	1				ath (Check only one	· • · · · · · · · · · · · · · · · · · ·	
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Division or Attending after death. Director: After	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, str			28f. Location (Stre	eet and Number or R	ural Route Number,
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Division of To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exa	/ knowledge, deat mination and/or in	h occurred at the ti vestigation, in my	ime, date and plac opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner at te and place, and du	s stated. e to the cause(s)
thin 24	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen			d. Date signed (Mon	
To To COLT		William	n 121	1		13238	29	June 9, 2	
		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type				, -	
		William Bair, M.I). 100 Br	amble St		idge, MD	21613		
S Regis	ate trar	31. Date filed (Month, Day, Year) 1 4	2005 ^{22. Registrar's S}	Signature	Andr				

		For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of	Health and of Death	Mental Hy	/giene Reg. No.	2005	21180
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) Betty Ade Ade A. Facility Name (If not institution, give see	elaide Hal	1	4b. City. Town	n, or Location of Dea	2. Date of Domenth June	Day 5	Year 2005 County of Death	3. Time of Death 8:55 a M
Funeral Director	er	Calvert Memorial E. 5. Social Security Number 6. Security Number 1577-34-1665	ospital	as <i>t birthday)</i> Yrs.		nce Frede	erick s. 8. Date of Bi	irth	Calvert 9. Birth	place (State or Foreign intry) h., D.C.
e Maryland ta-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Calves		, Town or Lo		Lomons				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Othar Tris marked othar than "natural", or itams 23a or 28a-f show othar traumatic evant, the Madical Examinating the notified at	Funeral Director	10e. Street and Number 13325 Dowell Road 11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	10f. Zip Cod 206 Was Decedent of Yes, specify C		Specify Yes or N		USA 14. Race - Amer Black, White	ican Indian,
72 hours after	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu	1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2 🔀 I	No Specify:			Specific	hite
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permit. Pages Department of important: If is any injury or on		21. Signature of Fureral Service License William R	Go	22 I	2. Name and Ad	dress of Facility Funeral Ho	ome, P.A	., (- 2	MD 20736
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cating that caused the death the cause on each line. Coronary Ar Due to (or as a consequ	tery I	_	dying, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death few months
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The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregna Other (specify			2	23d. Date of deliv Month	very Day Year
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To the Hospital or Attending within 4 hours after death of To the Funeral Director: Alte completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, offi	Ce		(Street and own, State)		al Route Number,
the Hospital or hin 4 hours afte the Funeral Dir npletely filled in	eclical	(Check only 2 Medicel Exemi	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deatl ion and/or in	vestigation, in m	y opinion, death occ	e, and due to the curred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
To t To t com	W	29b. Signature and title of certifier Thurse	and a		29c. Lic	9427			e signed (Month)	
Sta Registr		30. Name and address of person who co Anwar T. Munshi, M 31. Date filed (Month, Day, Year)		ital I	Rd., ste	e. 303, Pr	rince Fr	<u>ederi</u>	ck, MD	20678

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Hall June 5 2005 Russell David /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1**∑**M 2□F Yrs 79 Director 217-14-7997 June 12, 1925 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 la marked other than "natural", or Itams 23a or 28a-f ahow other traumatic avant, the Medical Examinar must be notified at 1♥Yes 2 No Director Chesapeake Beach Calvert 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20732 3151 Cox Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Ves 2 No within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1943–46 1 ☐ Yes 2 ₹ No Specify Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 well driller, pump mechanic well water & pump 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be fi Department of Health and Mental F Important: If itam 27 Is marked of any injury or other traumatic avai Stinnett 2 Swedie Oden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3151 Cox Rd., Chesapeake Beach, MD Janet D. Hall, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6-9-05 Alexandria, VA ° 4 □Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Cosonas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 Yes 2 No Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 Yes 2 No 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To 2× No 1 Tes 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of Certification: 28d. Describe how injury occurred After or Attanding 1 X Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No To tha Funaral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide after within 24 hours Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lmAoma 616 120027189 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 31. Date filed (Month, Day, Year, 32. Registr

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** Harrod Ida 2 5:45 P M June /Medical 4a. Facility Name (II not institution, give street and number)
Millennium Health & Rehab. Ctr. 4b. City, Town, or Location of Death Edgewater 4c. County of Death Examiner Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Pay, Year) June4,1912 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2√F 92 218-76-8633 Marvland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiana. Is marked other than "natural", or items 23a or 28a-f show 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov othar traumatic evant, it a Mouleal Extention outside or 1 ☐ Yes 2 ☑ No Marvland Calvert Owings Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Horace Ward Road 20736 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ¥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Farmer Farming permit. Pages 1 and 2 should be itie Department of Health and Menial Hy Important: if item 27 is marked other any injury or other traumatic event, ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hurlev Charles Priscilla Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 291 Owings, MD 20763-9326 Helen Hurley/Daug.-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. 6/7/2005 Chesapeake Bch., MD Edmonds UMC 22. Name and Address of Facility Sewell Funeral 1451 Dares Beach Rd. Prince 21. Signature of Funeral Service Licensee Home Fred., MD20678 Glady a. Semel 23a. Part1. Enter the lisease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrhythmia. Physician 5 minuter disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner therosclerofic Cardio vascular dixose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementiq 1 Yes 2 No 3 Probably 4 Minknown Be Completed Carcinoid metastatic 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypothyroidism. 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Proving Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending 1 Yes 2 No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50653 ilu. c 03 105 owana. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN -C. SURANA-

DHMH 17 Rev 1/2001

State

Registrar

5851-

31. Date filed (Month, Day, Year)

Deale

6 2005 ▶

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Deale

churchton

32. Registras Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2005 Rebecca L. Jones June 4:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Irothian

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5041 Solomons Road Island Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔼 F Director 213-05-0016 98 23 Dec. 1906 Marvland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits iral', or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5041 Solomons Island Road 20711 TISA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Iter 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: **Black** Completed by Specify 3 Widowed 4 □ Divorced treumatic event, the Mudical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Bd. of Education 4th 0 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygin moortent: if them 27 is marked any injury or other in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry johnson Mary Hardesty ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) Juanita Stanton (Daughter) 4601 Sutherland Circle Upper Marlboro, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Chews Church Cemetery 6/14/05 Owensville, Md. A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons MOrtuary, 1 821 West St. Annapolis, Md. P.A. 21401 Lary H. Rees mc048 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1440 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician ar s the burial-to s a consequence of) Box 68760. Physician/Medical as attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) P.O. the ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 No Division of Vital 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1 2 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide in 24 hou. 29a. Certifier 1 🕩 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8KEP) DONALED) 16/67 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

Baltimore, Maryland 21215-0036

IN	Li	remaine James Please	Type or Prin	nt in Blaci	k Indelible Ink	. Ensure Al	l Copies A	re Legible.	
		1 - For State Registrar	State of Ma		Department of F Certificate of		-	ene NG NO S	21101
Physicia	ın	1. Decedent's Name (First, Middle, La					2. Date of Death	2000	3. Time of Beath
/Medic	al	TREMAINE 4a. Facility Name (If not institution, giv	JAMES		4h Cihi Taur	al anning of Dooth	JUNE 6,	2005	4:32 A M
Examin	er	PRINCE GEORGE HOS	PITAL CENT		CHEVER				EORGES CO
Funeral Director		5. Social Security Number 255-47-7831 Usual Residence of Decedent	M 2□F	e (In yrs. last birt	hday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day, Y NOV • 11	9. Birt	nplace (State or Foreign untry) Georgia
r 28e-f show	tor	10a, State 10b. County D • C •		10c. City, Town Wash	or Location nington				10d. Inside City Limits 1 ☐Yes 2 ☐ No
h with the	Funeral Director	10e. Street and Number 2212 Irving S	treet,S.I	Ξ.	10f. Zip Code 2002	:0	10g	. Citizen of What Co	untry?
filed within 72 hours after death with the Marylend Hygiene. other than "natural", or Items 23a or 28e-f show ant, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Spr an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	e, etc.
n 72 hours "natural", edical Ex	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	eation during most of worki	ng 16	b. Kind of Business/	lack
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uld be file Mental Hy irked oth	To Be (17. Father's Name (First, Middle, Last, Jerome	James				(First, Middle, Ma. Chree	oden Sumame) Dupre	Э
nd 2 sho alth and N 27 Is ma or treuma		19a. Informant's Name/Relationship (Chree James	_{Туре, Print)} Mother	19b. 22	Mailing Address (Street 212 Irving	and Number or Rura	Nash.D.	ity or Town, State, Z	ip Code)
permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ny any injury or other treumatic event, the Med. 20128.		20a. Method of Disposition 1 ★ Burial 2 Cremation 3 1 4 □ Donation 5 □ Other (Specif		cemeter	Disposition (Name of y, crematory or other place rection C	ce)		c. Location - City or Clinton	
permit. Departimport any inj		21. Signature of Funeral Service Ligar	Hunt		22. Name and Addre	110		ral Home	
Physician /Medical Examiner	The second	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MULTIP	10.	SHOT W	ng, such as cardiac c	r respiratory arrest		Approximate Interval Between Onset and Death
uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence o	of):				
	icaj Exa	resulting in death) Last	Due to (or as a	a consequence o	of):				
rtificating phy as the	Medic	IE ESTATE							
The law requires that the death certificate be es to has been signed by the ettending physician bage 2 should be detached for use as the buria	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delin Month	very Day Year
quires that n signed b	by	Part II. Other significant conditions of	contributing to death bu	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
	Completed						24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
ician: certific actor.	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death	(Check only one)		
Phys	5 To	1X Yes 2 □ No 27. Manner of Death	1 L Inpatier 28a. Date of Injur	y 28b. T	ime of 28c. Injun	4 □ Nursing Hor	ne 5 🗆 Residence 28d. Describe how i	e 6 □Other (Speci niury occurred	(fy)
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tel or Atters ester de el Directo	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju building, etc	: (Specify)	m, street, factory, office			t and Number or Rui tate) EST, WASHI	al Route Number, NON X, VE
To the Hospitel or Attending Physician: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Pt (Check only one) 1 ☐ Medical Exam	niner: On the best of and manner sta	examination and	death occurred at the tin Vor investigation, in my o	ne, date and place, a pinion, death occurre	and due to the caus ad at the time, date	e(s) and manner as and place, and due	stated. o the cause(s)
Tot withi com	Σ	29b. Signature and title of certifier Oue T	diago,		29c. Licenso	Œ	Л	Date signed (Month, JNE 6, 200	5
nd		30. Name and address of person who	Completed cause of de	eath (Item 23a) (Type, Print 111 Penr	Street	Baltimore	e, Marylar	d 21201

31. Date filed (Month, Day, Year)
JUN 1 3 2005

32. Registrar's Sign

State Registrar

			1_ For State	State	of Marylar					and M	lental Hy	giene		
			Registrar 1. Decedent's Name (First, Midd	le (ast)		Ce	rtificate	OT L	Jeatn	<u>1</u>	2. Date of De	Reg. No.	05	21186
	Physici		Rosina	io, Lusty	Keller						Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution	n, give street and n		<u>C</u>	4b. City, 1	Town, or	Location of	of Death	June		2005 nty of Death	7:50P [™]
П			4426 Gallan				Wa	1do	rf				Char	les
	Funeral	П	5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.				If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th V Yearl	9. Birth	place (State or Foreign ntry)
	Director		212-58-5867 Usual Residence of Decedent	ILIM ZIZIF		95 Yrs.					May 29	, 1910	Minr	nesota
	wo		10a. State 10b. County	,	10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	Man a-f sh	tor	MD Charle	es	Wa	ldorf								1 ☐ Yes 2 🛣 No
	th the or 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Cou	ntry?
	ath wi	ral	4426 Gallant Gr				20	601				U.	S. A.	
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Madical Examiner must be motified at	by Funeral	11. Marital Status	Armed F			Was Decede If Yes, speci	ent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		ace - Ameri lack, White,	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Mar 3XX Widowed 4 ☐ Divorced	If Yes G	2XXIIIo live Dates:		1 ☐ Yes 2	XX No	Specify:			Spec	eify: Whi	**
Maryland 21215-0036	2 hou	ted	15. Deceder	nt's Education		16a. Dece	dent's Usual	Occupa	tion			16b. Kind of		
215	thin 7 e. an "n	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	kind of work DO NOT use	k done d e retired)	u <i>ring m</i> ost	t of worki	ng			
7	ed wil	Con	12			Owner	and (Bus Se		!
and Pure	be fill htal H od oth	Be	17. Father's Name (First, Middle, Martin Hartman	Last)							(First, Middle,		ime)	
$\frac{3}{2}$	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinational be rediffed at once.	To	19a. Informant's Name/Relations	hin /Time (Brint)		105 14-15		/0:			Brudge			•
Z	d 2 sl th an th an traur		Ellen B. Heilme		ighter						aldorf,			,
ē,	tam 2		20a. Method of Disposition	Jet / Dat	20b, F	Place of Dispo	sition (Nam	e of			oate 14,	20c. Location		
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altimore,	mit. I partm sortei / inju		21. Signature of Funeral Service		1									.Hme.,P.A.
m	F 5 F 8		Horiso 18	ast de	M00									MD 20622
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that only one cause on	caused the deat	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
i i	Physician		Immediate Cause (Final disease or condition		Can	ntus	17	+	- [1.0				Onset and Death
i.	/Medical Examiner		resulting in death)	Due to	(or as a cons	uence of):	1			-				
	LXammer	<u>.</u>	Sequentially list conditions,	b	(or as a consec	tung	سيد							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	de la	(or as a conseq	unne or):							- /2	
	al-tra	xar	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial transit	dlcal		d										
9	tificat ng phy as th	0	m				100.00.00							
Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna birth 2 Peta		Ectopic pre	onancy					ate of delive	*
	e dea the at	sicl	in the past 12 months? 1 ☐ Yes 2 MNo		nant at time of d		Other (spe					M	lonth	Day Year
P. O.	that the death certificed by the attending properties as	by Physiclan/M	9 ☐ Unknown Part II. Other significant conditi	one contributing to	doath but not rec	ulting in the co	ndoshina on		n in Dard I		22a Did to		ntributa to t	he cause of death?
Records,	w requires that been signed to should be det		(1)-01-		Death but not les	alang in the al	nuerlying ca	nza čiva:	ii iii Faiti.					pably 4 Unknown
Ö	v requ	Completed	1 to 1) ,	1-0-									
Re	he fav s has ge 2	dm	I hehad I	Cegury	Leven						24a. Was autop perfo	an sy rmed2	prior to con death?	psy findings available mpletion of cause of
Vital		e Co	25. Was case referred to medica	, ,					OC Diago	of Dooth	1 Tes	2 ▼ No	1 🗆 Yes	2 No
	ysician: The is certificate hidirector, page	0 8	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatien	it 3□ DOA	Othe			<i>(Check only o</i> ne 5 X Resid		ther /Snecif	iv)
Division of	ig Physiter this	i.	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date		28b. Time of		c. Injury Work			28d. Describe h			77
000	ttandir death. ctor: Af y the fur	atlo	2 Accident investi	gation	m, buy roury	injury	М		es 2 🗆 N	No				
Š	i or Att after de Directe	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Plac	e of Injury - At ho ling, etc. (Specif	ome, farm, str	eet, factory,	office		2	28f. Location (S City or Tox		ber or Rura	al Route Number,
	oltai durs al urs al erai D			Di di a										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To th Examiner: On the l	e best of my kno basis of examina nner stated.	wledge, death tion and/or inv	n occurred a vestigation, i	t the time in my opi	e, date and inion, deat	i place, a h occurre	and due to the a ad at the time, a	cause(s) and m date and place	nanner as st , and due to	tated. the cause(s)
	o the	Me	29b. Signature and title of certifie		The stated		29c.	License	number			29d. Date sign	ed (Month,	Day, Year)
	- > H- O		· 7L	nto	D		(100	201	11	9	6-1	0-0	5
<			30. Name and address of person				Print)					- 1	J 0	
	1B20		Henry Burke	e,M.D. P	.0. Box	x 2539	9,La		ta,M	ID 2	0646			
	Sta Registr		31. Date filed (Month, Day, Year)	1 3 2005 32.1	Registrar's Signa	ture	Speed	2						
	negisti	1		-	ACTION ACTION									

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 Certificate of Death Reg. No.	21187
Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) Chad Michael Lipscomb 4a. Fecility Name (If not institution, give street and number) 3800 block Bittingor Bood & OPrion Discontinuous Park County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth	County Iplace (State or Foreig Intry) Virginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygene. Importent: If teen 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evantinar must be notified at once.	rector	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
r death with ems 23a or er must be	Funeral Director	Gibson Street P.O. Box 80 26444 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amerin If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	ican Indian,
thours after atural; or it	þ	3 Widowed 4 Divorced If Yes, Give 1 Yes 2X No Specify: Specify:	White
led within 72 hours aft lygiene. her than "natural", or nt, the Medical Evamin	Completed		
Midly latter 4.2 should be file the and Mental Hy 7 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, Last) Walter Lee Moats 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	Codel
it. Pages 1 and 2 riment of Health a rient: If item 27 is njury or other trau		Loria Lipscomb P.O. Box 80 Tunnelton, WV 26444 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To	
permit. Pag Department Importent: any injury o		'4 Donation 5 Other (Specify) Mt View Cemetery Jun 16 2005 Tunnelton, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rotruck-Lobb Funeral	Home
rnysician /Medical		295 South Price Street Kingwood, WV 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the c	26537 Approximate Interval Between Onset and Death
Examiner sician and purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
death certificate a attending phy: d for use as the	Physician/Medic	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ery Day Year
es thz igned be de	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	ne cause of death? ably 4 □Unknown
The law ate has b page 2 sl	Completed	autopsy prior to con operformed? performed? I get No 1 yes	psy findings available inpletion of cause of
m	Certification; To Be	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28c. Place of Injury At home, farm, street, factory, office 28c. Place of Injury At home, farm, street, factory, office 28c. Place of Injury At home, farm, street, factory, office 28c. Place of Injury At home, farm, street, factory, office	Route Nymber.
To the Hosp within 24 hou To the Funer completely file	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month of	the cause(s)
3		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, December of Decem	
Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	nd 21201
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		-	For State Registrar	State of M	Maryland	-	artment of H		Mental Hy	ygiene Reg. No:?	2005	0 4 4 5 5
			Decedent's Name (First, Midd.	le, Last)					2. Date of D	eath	.000	Time of Death
	Physicia /Medic		GWYNN JUNIOR L	ASTER					JUNE	09	2005	11:26 P ^M
	Examin		4a. Facility Name (If not institutio		er)		4b. City, Town, or	Location of Death	1		County of Death	
			ANNE ARUNDEL M			a de l'ambie et accel	ANNAPOLI	If Under 24 Hrs.	2 Data of B		NNE ARUN	
	Funeral Director		5. Social Security Number 219-54-4195	6. Sex 1 X M 2 ☐ F	Age (In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of B (Month, D	Day, Year)	Cou	place (State or Foreign ntry)
	pu &		Usuel Residence of Decedent 10a. State 10b. County	,	10c. City, 1	Town or Lo	cation					10d. Inside City Limits
	faryla r sho	ō			CHES							1 ☐ Yes 2 X No
	28a-	Director	MD QUEEN 10e. Street and Number	ANNE'S	CHES	LEK	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	3a or	Ö	102 CEDAR ROAD				21619			USA		
	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or ltems 23a or 28a-f show event, if a Medical Exertiral rutal be mullised at	Funerai	11. Marital Status	12. Was Decede Armed Force	s?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No Rican, etc.)	io- 1	4. Race - Ameri Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Mai 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	⊐№ 1971 s: 1973	1	1☐Yes 2XNo	Specify:			Specify: W	HITE
21215-0036	2 hou	ted		nt's Education	1713	16a. Dece	dent's Usual Occupa kind of work done of	ation	kina	16b. Kin	nd of Business/Ir	ndustry
215	thin 7.	Completed	(Specify only night Elementary/Secondary (0-12)	est grade completed) College (1-40		life.	DO NOT use retired)	king .			
7	filed wil Hygien other the	Con	10			EQUII	PMENT OPER		(Ci 4 4 intel		ERNMENT	
nd	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It a Ma	Be	17. Father's Name (First, Middle,	,				18. Mother's Nan		ie, maiden s	Sumame)	
7	should be ind Mental markad o	으	HASKELL K. LAS			19h Mailir	ng Address (Street a	IDA L.		ber. City or	Town, State, Zi	o Code)
Maryland	d 2 sith an traur		AUDREY E. LAST				CEDAR ROAL			21619	_	•
ē,	s 1 and 2 should f Heelth and Men item 27 is marks other traumatic		20a. Method of Disposition	LIK/ WIII	20b. Plac	ce of Dispo	sition (Name of matory or other place		Date		cation - City or T	own, State
Baltimore,	permit. Pages 1 and 2 Depertment of Heelth a Importent: If item 27 is any injury or other tra <u>pnce.</u>		1 X Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (Specify)	WOOD PARK	LAWN	MEMORIAL	06/1	4/2005	EAS	STON, MD	
Ball	permit. Depert Import any in		21. Signature of Funeral Service	Licensee	1101	F	2. Name and Addres ELLOWS, HI 06 SHAMRO	ELFENBEII	N & NEW	NAM FI	UNERAL I 21619	HOME, P.A.
			23a. Part1. Enter the disease, c shock, or heart failure. Lis	or complications that caus	sed the death.	Do not en	ter the mode of dying	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Dr. 10	44 A C Q I	cca	l seas	รวิธ				Onset and Death
	/Medical		resulting in death)	Due to (or	as a conseque	nce of):	l sep					
	Examiner		Sequentially list conditions,		as a conseque							
	pel list	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	as a conseque	1100 01).						
	al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or	as a conseque	nce of):						
8760,	cate be executed physician and the burial-transit	dical		d								
9	rtificat ng phy as th	0 1	IE ECMAN E.									
Box	eath certific ettending p i for use as	an/h	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnand 1 2 ☐ Fetal d		Ectopic pregnancy			2	3d. Date of deliver Month	rery Day Year
	The law requires that the death certificate be execulate has been signed by the ettending physician and page 2 should be detached for use as the burial-transate.	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow	t at time of dea n	th 5[Other (specify)					
P.0	that the died by the detached		Part II. Other significant condit	ions contributing to deat	h but not resulti	ing in the u	inderlying cause give	en in Part I.	23e. Dio	d tobacco us	se contribute to	the cause of death?
Records,	signe d be	d by	Chronic 05	structive	pul.	mon	non d	iseuse	2. 15	Yes 2	□No 3□Pro	bably 4 Dunknown
COL	w requir been si should	iete	cirrohisis						24a. We			opsy findings available
Re	The lavele has	ompieted	CITIONS						aut per 1 🗆 Yes	topsy rformed?	prior to death?	ompletion of cause of 2 No
Vital		Ce	25. Was case referred to medic	al				26. Place of Dea				
	ys dis	To B	examiner? 1 Yes No	Hospital:	atient 2 El	R/Outpatie		4 Nursing F	iome 5 Re	sidence 6	Other (Spec	ify)
n of	ng Ph fter th neral		27. Manner of Death 12 Natural 5 ☐ Pend	28a. Date of (Month,	Injury 2 Day Year)	8b. Time o	Worl		28d. Describ	e how injury	occurred	
Sio	Attending ir death. ector: After by the fune	cati		tigation				Yes 2 □No	29f Lecation	/Ctroot and	d Number or Pu	al Route Number,
Division	or Ati	Certification:		mined 286. Place of	, etc. (Specify)	ie, farm, st	reet, factory, office			own, State)		ar noble Number,
	To the Hospitel or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer to the f		29a. Certifier Certify (Check only 2 Medica	ing Physician: To the be	est of my knowl	edge, deat	th occurred at the tin	ne, date and place	e, and due to thurred at the time	ne cause(s) e, date and	and manner as	stated. to the cause(s)
	the H the F the F	Medical	one)	and manner	r stated.		29c. License				e signed (Month	
	5 1 2 2 5 5	-	29b. Signature and title ol certif	Dr.				8510		06	1 1	05
	To the Hose within 24 hor To the Fune Completely fi		Sleph		of dozeh (lear)	3a) /T		010		- 0	() ()	
	3		30. Name and address of perso	n who completed cause	AA.	MC	. 2001 ME	DICAL PK	WY. ANN	ΙΑΡΟΤ.Τ	S. MD	21401
	Sta	ate	31 Date filed (Month Day Yea	r) 32 Bec	nistrar's Signatu	re	_				-,	
	Regist		JUN	1 4 2005	Klave	B	South					
DI		2001					-					

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JOHN I.LOURO JR. 05-04124 amend/unpend item/ 1,23a,27,23a f, pend (345,7/19/0) TT
State of Maryland / Department of Health and Mental Hygiene RKD 1 - For State Registrar 005 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death idn Isais Ioro, Jr. Day Month **Physician** Year JUNE 16, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK 102 E.SIXTH STREET 8. Date of Birth (Month, Day, Year) 8-13-1957 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F 47 Yrs. 220-74-8358 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at Frederick Maryland Frederick 1 XYes 2 No Directo 10f. Zip Code **21701** 10e. Street and Number 10g. Citizen of What Country? ò 102 East 6th Street U.S.A. 238 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 M2Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No white þ Specify 3 Widowed WiDivorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Disabled n/a 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be nd Mental is marked Josephine Gray John Isais Louro, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Gray - Mother item 27 10214 A. White Pelican Way, New Market, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town Pages nent of I permit. Pages Department of I important: if its any injury or o once. 1 💢 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 6/20/2005 Norbeck Memorial Olney, Maryland 21. Signaturé of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 lu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alcohol and oxycodone Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine inding physician and use as the burlat-transit the death certificate ba executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ρ in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. F ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 4 Winknown cate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No autopsy performed? certificate Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Scene Certification: To 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? Frid Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death, investigation 6/16/05 6:30 P 1 ☐ Yes 2 XNo 2 Accident unk Director 6 XCould not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 100 F filled in by 4 | Homicide Found at home 102 E. Sixth Street within 24 hours a To the Funeral C Frederick, MD Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME JUNE 17, 2005 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 1111 Penn Street Baltimore, Maryland 21201 HESDINE 2005 Registrat's Signature 31. Date filed (Month, Day, State Registrar

JET 05-03986 Theodore

eodo		ray		e of Maryland / De		ealth and Me	•	-	
	187		Registrar 1. Decedent's Name (First, Middle, Last)		ertificate of t		Reg.	² 005	2. Time of Dan
	Physici /Medic Examin	al	Theodore M. Layman 4a. Facility Name (If not institution, give street an	d number)	4b. City, Town, or	Location of Death	June	Day Year 10 2005 4c. County of Death	3:45 P M
		·	2352 Telegraph Road		Rising S	ıın		Cecil	
	Funeral Director		5. Social Security Number 6. Sex 723 18 7006 Usual Residence of Decedent	7. Age (In yrs. last birthda 75	ay) If Under 1 Year Months Days	If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Ye.) Oct. 29,19	ar) 9. Birth	place (State or Foreigr Intry) Land
	death with the Maryland ms 23e or 28e-f show trust be nutified at	tor	10a. State 10b. County Maryland Cecil	10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 No
	or 28e	Director	10e. Street and Number	Rising S	10f. Zip Code		10g.	Citizen of What Cou	intry?
	hs 23e or	raiD	2352 Telegraph Road		21911		Un	ited Stat	es
920	hours after de turel', or Items	by Funerai	1 Never Married 2 Married 1 X	Decedent Ever in U.S. ad Forces? Yes 2 No 1951- s, Give or Dates: 1953	 Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 2 X No 	spanic Origin? (Spec n, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
Maryland 21215-0036	n 72 ho "natur edical	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	eted) 16a. De (G (G)	cedent's Usual Occupa ive kind of work done of e. DO NOT use retired	ation during most of working ()	16b	. Kind ol Business/li	ndustry
121		Co	12 17. Father's Name (First, Middle, Last)	Self	Employed :			Farming	
anc	2 6 7 2	o Be	Murray Franklin Layman			18. Mother's Name (Augusta V.		len Sumame)	
ary.	es 1 and 2 should be lof Health and Mental litem 27 is marked or rother treumatic eve	2	19a. Informant's Name/Relationship (Type, Prin	1) 19b. M	ailing Address (Street a			y or Town, State, Zi	p Code)
	and 2 ealth a m 27 is		Connie Corron/Daughter		. Box 496,				,
Baltimore,	Ø = = 0		20a. Method ol Disposition 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other Specify	20b. Place of Discemetery,	sposition (Name of crematory or other place nk Cemeter)	e) Tuno 1	te 20c.	Location - City or T	
alti	permit. Pag Department Importent: I any injury o		21. Signature of Typera Service Licensee	//	22. Name and Address		uch Fune	ral Home	
_	20 E E 9		23a. Part1. Enter the disease, or complications		127 South I			East,Mary	land 21901
760, A	Physician by Secuted by Secured b	Jicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		shot w	aund of	head		Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as th	by Physician/Med	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date ol deliv Month	ery Day Year
	quires that n signed b ald be deta	ed by Pr	Part II. Other significant conditions contributing) to death but not resulting in the	e underlying cause give	en in Part I.		o use contribute to	he cause of death?
Vital Records,	@ CT	Completed					24a. Was an autopsy performed' 1 Yes 2	? prior to co	opsy lindings available ompletion of cause of
Z.	Physicien: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1X Yes 2 □ No Hospital:	451	Othe	26. Place of Death (
Division of	ding h. After fune	ation: To	27. Manner of Death 28a.	1 Inpatient 2 ER/Outpa Date of Injury (Month, Day Year) 28b. Time Injur	28c. Injury	4 Nursing Home	d. Describe how in	6 Other (Speci njury occurred t Shot	self
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, building, etc. (Specify)	street, lactory, office	28	Location (Street City of Jown Str	and Number or Run	al Boute Number,
	le Hospi 24 hour le Funer letely fill	dicai	(Check only 2 Medical Examiner: On	o the best of my knowledge, de the basis of examination and/or manner stated.	eath occurred at the tim				
	To th withir To th comp	Me	29b. Signature and title of certifier	. 00-	29c. License		29d. I	Date signed (Month,	Day, Year)
	2 Za		Yatu Una	me tolle	m 00	MF	Jui	ne 11	2005
	10,7	E1	30 Name and address of person who completed	iva. Yollak	N.11 Penn	Street I	Baltimore	, Marylan	d 21201
	Sta Registi		31. Date filed (Month, Day, Year) JUN, 1 3 2005	2. Registrar's Signature	arle				

DHMH 17 Rev 1/2001

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		For State	State of M	aryland /	Department of I		nentai Hyg	200	5 21101
		Registrar			Certificate of	Death	1	eg. No.	
Physic	ian	Decedent's Name (First, Middle,	Last)				2. Date of Dea Month		3. Time of Death
/Med			ENT		ITTLEBE		JUNE	8 200	
Exami	ner	4a. Facility Name (If not institution,	give street and number	7)		or Location of Death		4c. County of	Death
		CHESTER RIV	SER HOSPI	TAL CE		4 ESTERT	OWN		ENI
Funera			6. Sex 7. A 152tM 2□F	ige (In yrs. last b 78	irthday) If Under 1 Year Yrs. Months Days		8. Date of Birth (Month, Day May 21	Year)	Birthplace (State or Foreign Country)
Director		050-26-5675 Usual Residence of Decedent		70	110.		May ZI	1927	New York
land		10a. State 10b. County		10c. City, Tox	wn or Location				10d. Inside City Limits
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ING X IX I 3-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itams 23a or 28a-f show event, Ita Madral Exeminar mark be notified at	Funeral Director	14175 W. Bee	echwood Ro	d.	2163	5		U.S.A.	
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Billy Mills 05-03932 NJM .

Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam are must be troitlisted.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 $\,^{o}$

	State of Manuand	/ Donortmon	of Health a	and M	ontal Hygi	ono		
For State	State of Maryland		te of Death	and w			_	
Registrar Decedent's Name (First, Middle, Las	st)	Commodi	o or boatin		2. Date of Death	g. No 20	05	2 Time of Deal
Billy Leo	•				Month	Day 8	Year 2005	100%
		4h Cih.	Town as Legation	of Dooth	June	4c. County		1824
a. Facility Name (If not institution, give			Town, or Location of	Di Death				
Dorchester General Soci			nbridge	24 Hrs	8. Date of Birth	DOLG	heste	
	M 2□F 66	Yrs. Months		Min.	Month, Day, Dec. 15			lace (State or Fore try) yland
0a. State 10b. County MD Dorch		own or Location	Crochero	n	-		10	0d. Inside City Lim 1 ☐ Yes 2 🛣
10e. Street and Number 2843 Crocheron	Road	10f. Zip	Code 2162	7	10	g. Citizen of V USA		try?
I 1. Marital Status	12. Was Decedent Ever in U.S.	13. Was Dece	dent of Hispanic Ori scify Cuban, Mexican	gin? (Spe	ocify Yes or No-	14. Race	e - Americ	an Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If Yes, spe	,		Rican, etc.)	Specify	ck, White, o	ite
15. Decedent's Ed (Specify only highest gra	ade completed)	6a. Decedent's Usu (Give kind of wo life. DO NOT u	val Occupation ork done during mos use retired)	t of worki	ng 1	6b. Kind of Bu	usiness/Ind	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)		aterman			S	eafo	od
7. Father's Name (First, Middle, Last))		18. Mothe	er's Name	(First, Middle, M			
Elmer Kenneth M					avelle E		•	
		10h Mailing Adda						Code)
9a. Informant's Name/Relationship (19b. Mailing Address				-		Code
David Mills Da. Method of Disposition	nephew	ZZ4 MIIQQI e of Disposition (Na.	le Blvd.,			1D 218 0c. Location -		
11. Signature of Funeral Service Licer		700 Lo	nd Address of Facili		omas Fur bridge,		Iome I 613	P.A.
	one cause on each line	Do not enter the mod	de of dying, such as	cardiac c	r respiratory arre	st,		Approximate
Immediate Cause (Final disease or condition resulting in death)	a. Atheroscles of Due to (or as a consequent) Due to (or as a consequent)	tic can	de of dying, such as					Approximate Interval Between Onset and Death
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State Registrar 31. Date filed (Month, Day Year) 1 5 200 32. Recorrar's Signature

Please Type or Print in Black Indelible ink Ensure All Copies Are Legible. Amend 1 tem 26 per verbal 846 8-1-05 vt State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month John Thomas Miller 13:32 17. 2005 lune /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY SACRED HUSPITAL HEART | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb. 10 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1931 1**⊠**M 2□F 74 170-30-9224 Director Yrs. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show ar than "netural", or items 23e or 28e-f show the Medical Examinar must be notified at Garrett MD. Bloomington tXXYes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO Box 16 Hamill Ave. 21523 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Exes 2 □ No Korean If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 21 No þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit, Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "ne any injury or other treumatic event, It a Madic 2006. Elementary/Secondary (0-12) College (1-4or 5+) Banking Banker unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey F. Miller Etta Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 3rd St., Baiden, Pennsylvania Betty Farris/ sister 15005 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 06/20/ 2005 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Cumberland, Maryland Cumberland Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 7. Wa 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ofset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neu-me /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, but sause or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit ding physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2/2 No 1 🗆 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the I Director: 6 Could not be determined 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Fo the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0015463 Name and address of ers who empleted cause of death (Item 23/) (Type, Print) Westernport Mary 90 Main Stree . Kim 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

				partment of Health and Mental ertificate of Death	Hygiene 2005 21194
I	Physici		Decedent's Name (First, Middle, Last) SAMUEL LEE MOATS	2. Date of Month JUNI	of Death 3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 3800 BLOCK BITTINGER ROAD	4b. City, Town, or Location of Death SWANTON	4c. County of Death GARRETT
	Funeral Director		5. Social Security Number 236-21-5390 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 22 Yrs.	Months Days Hours Min. (Mont)	of Birth h, Day, Year) 19, 1982 9. Birthplace (State or Foreign Country) WV
	he Maryland 8a-f show	Director		WOOD	10d. Inside City Limits 1 ☐ Yes 🛣 No
	3a or 2		ROUTE 1, BOX 1133	10f. Zip Code 26537	10g. Citizen of What Country? USA
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-1 show other treumatic event. Ite Medical Ever free must be rediffied ut	by Funeral		Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2XI No Specify:	or No- 14. Race - American Indian.
21215-0036	filed within 72 ha Hygiene. other then "natur ent, Ine Medical	Completed	(Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) STUDENT	16b. Kind of Business/Industry N/A
Maryland 2	should be filed and Mental Hygis s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) WALTER LEE MOATS	18. Mother's Name (First, Mi KAREN SUE	iddle, Maiden Sumame)
Mary	12 sho h and h 7 Is ma reuma			ing Address (Street and Number or Rural Route N	
Baltimore, I	Pages 1 and 2 nent of Health out: If item 27 int or other trees		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cr	UTE !, BOX 1133, KINGWO osition (Name of paratory or other place) T CEMETERY JUN 16, 200	20c. Location - City or Town, State
Balti	permit. Pages in Department of H Importent: If ite any Injury or ot once.				L-LOBB FUNERAL HOME
	Physician		23a. Part 1 Enter the disease, or complications that caused the death. Do not e show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. MULTIPLE INJURI resulting in death)	iter the mode of dying, such as cardiac or respirato	
8760,	Medical Examiner ohysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	quires that t an signed by ruld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the		Did tobacco use contribute to the cause of death? ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown
		Completed		a	Was an autopsy autopsy prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatie	26. Place of Death (Check of not 3 DOA Other: 4 Nursing Home 5 DF	
	or Attending tter death. irector: After n by the fune	Certification: T	27. Manner of Death 1 Natural 2 X Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 06-11-05 28b. Time (Month, Day Year) 12:5 28e. Place of Injury - At home, farm, so building, etc. (Specify)	of 28c. Injury at Work? O M 1 Yes 2X No ACCII reet, factory, office 28f. Locatic City or	DENT on (Street and Number or Rural Route Number, Town, State) 1 November 1 November 1 November (November)
	Hospite 4 hours Funerel ely filled	edical Ce	29a. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/or i and manner stated.	ET BITTIN	MGER RD OBRIEN RD SWANTON
)	To the within 2 To the Complet	Me	29b. Signature and title of certifier	29c. License number H26154	29d. Date signed (Month, Day, Year) JUNE 20, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type PAUL DANIEL MILLER, D.O., 69 WOLF A		21550
: ,	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 0 2005 32. Registrar's Signature	V. 20 10 10 10 10 10 10 10 10 10 10 10 10 10	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Frederick Ralph McClure 2005 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) Aug 24, 19 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 3 M 2 ☐ F 71 168-26-2807 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow ral', or Itams 23a or 28a-f ahov Examiner must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Franklin Washington TWP PA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17268 USA 423 Old Mill Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene and Hitten 27 is marked other than "natural", or Italy or other traumatic event, Italy M. Jical Ex. nife Lay or other traumatic event, Italy M. Jical Ex. nife and Jical Ex. n 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 1953-55 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping clerk Ordnance depot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isabel T. Freet Emory F. McClure 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 Old Mill Rd. Waynesboro, PA 17268 wife Marilyn D. McClure 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If its any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Burns Hill Cemetery | Jun 22 2005 Waynesbore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, 21. Signature A Funeral Service Licenses 50 S. Broad St. Waynesboro, PA 17268 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Imbolism Ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to (or as a consequence of): Examiner transit Vein certificate be executed I h mbosss and resulting in death) Last burial-t P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy 1 Live birth o Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 1 -Natural Injury 5 Pending after death. 1 Tes 2 No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funaral I Hospital 29a. Certifier terifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D58267 10-20-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 Medial Campus Hax-ML DU 31. Date filed (Month, Day, Year) State 7 2005

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			1- For State of Maryland Registrar		rtment of Heal			ene .NO O O C	0:10
			Decedent's Name (First, Middle, Last)				2. Date of Death	2003	3. Time of Dat
	Physici: /Medic		Ida H. McLendon			J	une 6, 2	2005 Year	11:55 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	ation of Death		4c. County of Deat	h
			Layhill Center		Silver Spr			Montgomer	
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. las</i> 1 M 2 🗵 F 73	st birthday) Yrs.	If Under 1 Year If U Months Days Ho	ours Min.	B. Date of Birth (Month, Day, Y	9. Birti Co	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent				reb 10,	1932 Wade	sboro NC
	yland		10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-f s	ctor	DC Wash	ingto	n				1y∑Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?
	ath w	ra	905 Savannah St SE		20032			ited Stat	
	er de Itams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	. 13. V	Vas Decedent of Hispani Yes, specify Cuban, Me	ic Origin? (Spec exican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
36	Irs aft	by F	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	☐ Yes 2X No Spe	ecity:		Specify:Bla	ck
ğ	2 hou	ted	15. Decedent's Education	16a. Deced	ent's Usual Occupation		16	b. Kind of Business/	Industry
215	thin 7 e. an "m	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done during OO NOT use retired)	most of working	7		
2	od wil	Con	12	Teach	er		P	ublic Sch	001s
D L	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or Itams 23e or 28e-f show event, the Medical Examinat must be nullied at	Be	17. Father's Name (First, Middle, Last)		18. 1	Mother's Name (First, Middle, Ma.	iden Sumame)	
3	should ind Men marke umatic	P	Eugene Howard	405 11.75			Smith		
Maryland 21215-0036	O		19a. Informant's Name/Relationship (<i>Type, Print</i>) Bernard McLendon / Husband		_{g Address (Street and N} avannah St				ip Code)
ō,	os 1 and 2 of Health item 27 l		20a. Method of Disposition 20b. Pla	ce of Dispo	sition (Name of	Da Da		c. Location - City or	Town, State
9	Pages nent of I int: If it				natory or other place) an Cremator	y 6-8-20	005 A1	exandria '	Va
altimore,	permit. Pages Department of Importent: If it any injury or o		21. Sign for Funeral Service Licensee	22	. Name and Address of F	Facility Pone	Funera	1 Home	
m			Jalina M X 1000		617 Penn Av				
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition Respiratory	Failu	ıre				Onset and Death
	/Medical Examiner	1	resulting in death) Due to (or as a conseque						
	LAGITITIE	er	Sequentially list conditions, b. Sepsis						
	ted 1sit	ulue	if any, leading to immediate Due to (or as a conseque cause. Enter Undertying Cause Unsease or injury	ince or):				3	
	axecu n and al-trai	Examin	Cause (Disease of injury that initiated events resulting in death) Last C. Due to (or as a conseque	nce of):					· · · · · · · · · · · · · · · · · · ·
8760,	icate be executed physician and s the burial-transit	dical	d						
9	tifficat ng phy as th	00 1							
Box	th cer tendir rr use	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal of		Ectopic pregnancy			23d. Date of deli	
Б	e dea the att	sici	1 Yes 2 No		Other (specify)			Month	Day Year
<u>a</u>	The law requires that the death certificate has been signed by the attending to bage 2 should be detached for use as		9 Unknown Part II. Other significant conditions contributing to death but not result	ing in the	Marking access are in I	Dodl	22a Did tobac	cco use contribute to	the seven of death?
Records,	signe d be d	d by	Multiple Sclerosis	ing in pro ui	idenying cause given in i	rditi.			obably 4 □Unknown
Š	w requir been si should I	etec	Diabetes Mellitus				7		
Rec	nysicien: The law nis certificate has b director, page 2 s	Completed					24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
		e Co	Hypertension 25. Was case referred to medical		00	Dt4 D4	1 Yes 2 K	No 1 ☐ Yes	2 No
>	Physicien: this certificated rail director,	OB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	R/Outpatien	Othor			e 6 ☐Other (Spec	rifu)
0	- c	L:u	27. Manner of Death 28a. Date of Injury 2	8b. Time of Injury	28c. Injury at Work?		d. Describe how		,
Sior	Attending r death. sctor: After by the funer	atlo	2 Accident investigation	Hijary	M 1 ☐ Yes	2 🗆 No			
Division of Vital	l or Attenation after deatl	ertiflcation;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office	28	f. Location (Stree City or Town, 5	et and Number or Ru State)	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	O	On Continue 18 Continue 2			ık			
	Hospital 24 hours a Funeral stely filled	edical	29a. Certifler 1	ledge, death on and/or inv	i occurred at the time, da restigation, in my opinion	ate and place, an n, death occurred	d due to the caus I at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	-	29c. License num	nber	29d	. Date signed (Month	n, Day, Year)
	1		Istronine Rulbano	7	D566	91	т	uno 0 000	25
	ac		30 Name and address of person who completed cause of death diego.	(Type	Print)			une 8, 200	
_	Ø (Dr. Ghdysia Sultana MD 12102 H	erita	ge Park Cir	cle Sil	ver Spri	ng MD 2090	06
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	re					
	Regist	air	JUN 1 3 2000 Black	20					

•		1 - For State Registrar	C	partment of Health and I Prtificate of Death	R	eg. N2 0 0 5	21198
Physic	an	1. Decedent's Name (First, Middle, Last) Agnes Nw			2. Date of Dea Month June 2	Day Year	3. Time of Death 6:18A M
/Medi Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	0.10A
LAGIIII		Holy Cross Hospi	tal	Silver Spring		Montgome	ry
Funeral Director		None	7. Age (In yrs. last birthda M 2 F 70 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day July 28	, 1934 Nige	place (State or Foreign htry) ria
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		1.	10d. Inside City Limits
he Maŋ 28a-f sh otified	ector	Maryland Montgome 10e. Street and Number	ry Silv	er Spring		0.00	1X Yes 2 □ No
th with 1 23s or 3	ai Dir	23 Silver Moon Dr	ive	10f. Zip Code 20904		Og. Citizen of What Cou Nigeria	ntry ?
within 72 hours after death with the Maryland ane. then "natural", or Items 23a or 28a-1 show ha Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert □ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
vithin 72 ho ne. hen "natur Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) (Gi College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of work DO NOT use retired) Ool Principal	king	16b. Kind of Business/In	
uld be filed w Aental Hygie rked other ti tic event, in	To Be Col	17. Father's Name (First, Middle, Last) Ibeodo	4 Sell		ne (First, Middle, i		
and 2 should ealth and Men n 27 is merke ier treumatic	ľ	19a. Informant's Name/Relationship (Ty Pearl Akagha/Dau		iling Address (Street and Number or Ru Silver Moon Drive;			20904
t. Pages 1 riment of Ho rient: If Iter njury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) 21. Signature of Funeral Sarvice Licens	Removal from State St. Sil Lown Ce	22. Name and Address of Facility P	17, 2005 ope Fune	20c. Location - City or To Nmo State ral Homes	, Nigeria
permi Depa Impo eny ii) ava	Willel	1 S	1315 Loc ilver Sp	kwood Drive ring, MD.	20904
Physician /Medical		23a. Part1. Enter the disease of compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not energy cause on each line. Biliary Duct Ca Due to (or as a consequence of):		or respiratory arr		Approximate Interval Between Onset and Death ew Months
icate be executed by physician and physician and sthe burial-transit	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of): Due to (or as a consequence of):				
the death certify the attending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year
w requires that s been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to tl es 2 □ No 3 □ Prob	
The law ate has b page 2 sl	Completed					ry prior to co ned? death? 2x No 1 ☐ Yes	psy findings available mpletion of cause of 2 No
ing Phys ifter this ineral di	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 2 ER/Outpat 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3☑ DOA Other: 4 □ Nursing H		e) ence 6 Other (Specification of the control of th	y)
ie Hospitel or Attending n 24 hours after death. se Funerel Director: After pletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (St City or Town	reet and Number or Rura n, State)	il Route Number,
To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I	edical	29a. Certifier 1 ☆ Certifying Phy. (Check only one)	sicien: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the carred at the time, d	ause(s) and manner as state and place, and due to	tated. the cause(s)
To the l	M	29b. Signature and title of certifier	n. White MC	29c. License number D0043539	2	9d. Date signed (Month, June 2, 200	
Se		30. Name and address of person who co Raymond White,	mpleted cause of death (Item 23a) (Typ M.D. 1500 Forest	e Print) Glen Rd., Silver S	pring, M	D. 20910	
St Regist		31. Date filed (Month, Day, Year) JUN 1 3 2005	32. Registrar's Signature				

			1 - For State Registrar	State of Maryland / D		lealth and M	ental Hygior	•	21199
	Physici /Medic	al	Decedent's Name (First, Middle, Lass Bertle L. Prit 4a. Facility Name (If not institution, give	chett	4h City Tours	r Location of Doub	2. Date of Death Month June 11,	Day Year	3. Time of Death 8:10 p M
	Examin Funeral Director	er	Chesapeake Woods 5. Social Security Number 6. S	Center ox 7. Age (In yrs. last birth	Cambr	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yei May 6, 19		
)	death with the Maryland ms 23a or 28a-f show	Irector	Usual Residence of Decedent 10a. State 10b. County Maryland Dorchest 10e. Street and Number	10c. City, Town	or Location Sambridge			Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	be filed within 72 hours after death with the Marylar ital Hyglene. Id other than "natural", or flems 23a or 28a-f show other than "natural", or flems 23a or 28a-f show event. It a Maciliar Extractional be notified at	by Funeral Director	1112 Race Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubs 1 Yes 2 No		ecify Yes or No- Rican, etc.)	USA 14. Race - Ame Black, White	e, etc.
21215-0030	d within 72 hours after giene. sr than "natural", or the the Modical Extendine	Completed b	(Specify only highest gra	ducation 16a. I (de completed) (Decedent's Usual Occup Give kind of work done life. DO NOT use retired Crab Picker	during most of worki	ng 16b.	Kind of Business/	
Maryland	should be file ind Mental Hyg is marked othe umatic event.	To Be C	17. Father's Name (First, Middle, Last) Carvey W. Mills 19a. Informant's Name/Relationship (-	Mailing Address (Street	Louisa	(First, Middle, Maid Meredith Il Route Number, Cit		Zip Code)
saltimore, Mi	permit Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic we one.		Nelson M. Mills, 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif	Jr./Son Removal from State Dorche	506 Camelot Disposition (Name of crematory or other places sterMemPark	Dr., Bel	air, MD 20c.	21015 Location - City or	Town, State
Dain	Deparim Deparim Importa any inju		21. Signature of Pilneral Service Licer	phosophis that caused the death. Do not one cause on each line.	22. Name and Addre Curran-Bro 308 High S	ss of Facility omwell Fun the Cambr	eral Home	, P.A. 21613	Approximate
	Physician /Medical Examiner		sheek a heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to for at a consequence of the consequence o	hast fa	Ture I'm	2010/		Interval Between Onset and Death
8/00,	cate be executed obysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence of d.	1).				year
O. Box 6	the death certific y the attending p iched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes > No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	,		23d. Date of del	ivery Day Year
ords, P	law requires that the de as been signed by the a 2 should be detached	by	Part II. Other significant conditions o	ontributing to death but not resulting in	the underlying cause giv	en in Part I.		2 No 3 Pr	o the cause of death?
Ital Rec	The lay ate has page 2	Be Completed	25. Was case referred to medical examiner?			26. Place of Death	24a. Was an autopsy performed 1 Yes 2	prior to d	topsy findings available completion of cause of 2 No
sion of v	ng Phys ter this neral dii	ation: To	1 Yes No 27. Manner of Death Natural 5 Pending 2 Accident investigation		me of 28c. Injur	4 Nursing Hor	me 5 Residence 28d. Describe how in		cify)
DIVISION	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify) sysician: To the best of my knowledge,	death occurred at the tir	ne, date and place,	28f. Location (Street City or Town, St and due to the cause	ate)	stated.
	To the H within 24 To the Fr complete	Medical	29b. Signature and title of certifier	niner: On the basis of examination and and manner stated.	29c Licens	a number	204	Date signed (Magt)	h Day Year)
			Michael D. Cro	completed cause of death (Item 23a) (1	Type, Print) Dutchman	: Lane,	Easton	MD	21601
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. Agistrar's Signature	for				

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

M.D.

32. Registr

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Man	•	ertificate of			Reg. N6)	A5_	21201
	Physici		1. Decedent's Name (First, Middle, Last) PEARL L. PALMQUIST	•				2. Date of De Month JUNE	Day	2005	2:45 PM
	/Medic Examir		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, o	or Location of De	ath	4c. County	of Deeth	
			661 QUAIL RUN COUR	T		ARNOLD			ANNE	ARUN	DEL
	Funeral Director		160-32-6603	7. Age (I	n yrs. last birthda 90 Yrs.	Months Days	If Under 24 H Hours Mi		rth ay, Year) 28 15	9. Birthp Cour PA	place (State or Foreign ntry)
	iryland show	_	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or	Location				1	10d. Inside City Limits
	Ba-f s	Director	MD ANNE ARUN	DEL .	ARNOLD						1 ☐ Yes 2 No
	with th	급	10e. Street and Number	_		10f. Zip Code			10g. Citizen of	What Cour	ntry?
	sa 234	eral	661 QUAIL RUN COUR	. Was Decedent Eve	er in IIS 12	21012 . Was Decedent of I	dienanie Origin?	(Specify Ves or N	USA	co - Ameri	can Indian,
136	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. is marked other than "natural", or items 23s or 28s-f show aumatic event, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 🗶 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	, III U.G.	If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)	Bla Specif	ck, White,	
ž	2 hou		15. Decedent's Educa	ition	16a. Dec	edent's Usual Occup	pation		16b. Kind of B	usiness/în	idustry
Maryland 21215-0036	l within 7 iene. r than "n It e Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12) 8	College (1-4or 5+)	life	e kind of work done DO NOT use retire EMAKER	during most of w	vorking	OWN HO	OME	
9	illed Hygid other	Be C	17. Father's Name (First, Middle, Last)		1		18. Mother's N	lame (First, Middle	, Maiden Surnar	ne)	
<u>la</u>	uld be Mental rked c	To E	OSCAR SJOBERT				HILDA	G. NIEST	ROM		
a	is 1 and 2 should of Health and Men item 27 is marke other traumatic.		19a. Informant's Name/Relationship (Type	e, Print)	19b. Ma	ling Address (Street	and Number or	Rural Route Numb	er, City or Town,	State, Zip	Code)
	and ealth m 27		GLORIA PFISTERER/DA			QUAIL RUN	CT., AF				
Baltimore,	Pages 1 nent of H ant: If ite ury or oti		20a. Method of Disposition 1	moval from State	20b. Place of Dis cemetery, cr TWIN VAI PARK	ematory or other pla LEY MEMOR	TAT	Date 11/2005	DELMON		
Balt	permit. Pages Department of Important: If it eny injury or gance.		21. Signature of Funeral Service Licensee	Lies	ett 1	22. Name and Addre ELLOWS, E LO6 SHAMR(ess of Facility IELFENBE OCK ROAD	IN & NEWN	NAM FUNE R. MD 2	RAL E	HOME, P.A.
	Physician		23a. Part1. Enter the disease, or complicion shock, or heart failure. List only one Immediate Cause (Final	ations that caused he cause on each line.	e death. Do not e		ng, such as card				Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c		7 4 4 9 4	``				Montas
	Examiner		Sequentially list conditions								
1	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):						
	ecute and trans	Examln	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a c							
60,	licate be executed physicien and s the burial-transit	E	1	Due to (or as a c	orisequence or).						
68760,	physicate s the	edical	d.								
Box	ath certii ittending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	c. If yes, outcome of p 1 Live birth 2 [4 Pregnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			te of delive	ery Day Year
P.O.	that the de ned by the a detached t	hys	9 Unknown	9□ Unknown							
rds, F	tuires tha n signed uld be del	by	Part II. Other significant conditions control Hype	ibuting to death but r		underlying cause giv	ven in Part I.		tobacco use cont Yes 2 ZNo		he cause of death?
00	w require s been si should t	Completed						24a. Was		Were auto	opsy findings available
æ	The law sate has page 2 :	E					-	- auto perfo 1 ☐ Yes	omed?	prior to coi death? 1 ☐ Yes	mpletion of cause of
ā		0	25. Was case referred to medical				26. Place of D	eath (Check only			20,10
>	nysici	To B	examiner? 1 ☐ Yes 2 🛣 No Ho	spital: 1 🗆 Inpatient	2 ER/Outpati	ent 3 DOA Ott	ner: 4 Nursing	Home 5 Pes	idence 6 Oth	er (Specif	5 /)
Division of Vital Records,	Attending Physician: or death. ector: After this certification of the funeral director.		27. Manner of Death 1	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury	Wo	ry at rk? Yes 2 □No	28d. Describe	how injury occur	red	
Divis	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (treet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of m er: On the basis of ex and manner stated	amination and/or	ath occurred at the ti investigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as st	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
)			BUSEN	_	MD	0	16964			6-9	1-05
6	SVX		30. Name and address of person who com	apleted cause of deat	h (Item 23a) (Type	e, Print) chic H	vy A	vuo V	MD	210	917
1000	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 3	32. Register's	Signature	Source)			

		•	For State Registrar	State of Marylar		rtment of I			iene 005	21202
	Physicia /Medic			LANCHE K. I	REDGRA	VE		2. Date of Deat Month JUNE 7	h Day Year 7, 2005	3. Time of Death 7:15 P M
	Examin		4a. Facility Name (If not institution, give s GOLDEN CREST AS 5. Social Security Number 6. Sex	SISTED LIV		4b. City, Town, WESTM			4c. County of Death CARROLI	J
	Funeral Director			M 2XF 9	1 Yrs.	Months Days		8. Date of Birth (Month, Day, 6 / 28 /	1913 MAR	place (State or Foreign ntry) YLAND
	he Marylan 28a-f show otified at	ector	MD CARROL		WESTM	INSTER				10d. Inside City Limits 1 XYes 2 No
	h with th	al Dir	10e. Street and Number 51 CHASE ST.			10f. Zip Code 2115	57	1	Og. Citizen of What Cou USA	intry?
920	d within 72 hours after death with the Maryland Jiene, Han "natural", or Itama 23a or 28a-1 show Itte Medical Exam per must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cub	Hispanic Origin? (S van, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify: WHI	, etc.
Maryland 21215-0036	I withIn iene. r than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2		(Give	DO NOT use retire	during most of wor	rking	16b. Kind of Business/Ir	·
yland	should be filed ind Mental Hygis marked othar umatic evant,	To Be C	17. Father's Name (First, Middle, Last) WILLI	AM	DAVIS		18. Mother's Nan CARRIE	ne (First, Middle, M	Maiden Sumame) DAYHOFF	
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any njury or other traumatic 20059.		19a. Informant's Name/Relationship (Typ. GLENN W. DAVIS 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. gnat	- NEPHEW amoval from State PIPI	49 C Place of Dispo cemetery, cren E CREE	HASE ST sition (Name of natory or other pla K CEME	r., WEST	MINSTER Date 1/05	City or Town, State, Zi, R, MD 21 2 20c. Location - City or T NEW WINDS FUNERAL F	157 own, State DR, MD.
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complic shock or heart fadure. List only on Immediate Cause (Final disease or con-lition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duy to (or as a consection to for or as a consection)	th. Do not ent	er the mode of dy		or respiratory arre	INSTER, MI	Approximate Interval Between Onset and Death
.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burlat-transit	Physician/Medical Examiner	resulting in death) Last	Due to (or as a consection of pregnant at time of a pull of the consection of the co	ancy al death 3	Ectopic pregnanc			23d. Date of deliving Month	91 y
Records, P.(w requires that the been signed by should be detact	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
al Reco	The ate h page	e Completed	25. Was case referred to medical					24a. Was al autops perform 1 Yes 2	y prior to connect? death?	opsy findings available ompletion of cause of
Division of Vital	attending Physical death. ctor: After this y the funeral dis	Certification; To Be	examiner?	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - Athough the building, etc. (Special Control of the Contr	ER/Outpatien 28b. Time of Injury nome, farm, str	M 1	her: 4 🗆 Nursing H	28d. Describe ho	ince 6 X Other (Speci w injury occurred	HIVING
	Hospital 4 hours a Funeral I ely filled	Medical Ce	29a. Certifier (Check only one)	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or in	n occurred at the t	ime, date and place opinion, death occu	, and due to the ca	ause(s) and manner as a	stated. to the cause(s)
)	To the within 2 To the complete	Me	20h Siensture and title of confider	niddletm		D25	se number	2	9d. Date signed (Month)	Day, Year)
	Sta Registr		JOHN W. MIDDLETO 31. Date filed (Month, Day, Year)		POOLE		STMINST	ER, MD.	21157	

			1 - For State of Maryland / Dep	eartment of Health and Nertificate of Death	Mental Hy		
	Physici	an	Decedent's Name (First, Middle, Last)	Timodio or Dodin	2. Date of D	eath Day	5 2 Tm-2 10 th3
	/Medic	al	Glenn Robert Samson		June 6		16:42 M
	Examin	er	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederick		4c. County of	
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Bi	Calve	
	Director		506–32–4072 X M 2□F 78 Yrs.	Months Days Hours Min.	(Month, D	ay, Year)	9. Birthplace (State or Foreign Country) Nebraska
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	conting			
	Aaryla f sho	ō		ocation			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	28a-	Director	Maryland Calvert Lusby 10e. Street and Number	10f. Zip Code		10g. Citizen of Wh	nat Country?
	h with		97 Brooks Cove Drive	20657		United St	tates
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto	pecify Yes or N		- American Indian, , White, etc.
30	s afte	by Fu	1 Never Married Married 10 Yes 2 No	1 ☐ Yes 2 No Specify:	o 1 110a11, 010.)	Specify:	
1215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Medical Examiner must be multiled at	ed b	Notea	edent's Usual Occupation		16b. Kind of Bus	White
715	nin 72	piet	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	king	Departme	ent of
	ad with giene er tha	Completed	College (1 ⁴ or 5+) Diplo	mat		Agricult	cure
Maryland 2	should be filed within 72 hours after death with the Marylar nd Mental Hygiene. I marked other than "natural", or items 23s or 28s-f show umatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)			a, Maiden Surname,)
<u> </u>		P _L	Maurice Samson	Cecilia			
<u>a</u>	C1 60 75 60			ing Address (Street and Number or Ru COOKS COVE Drive,			
ē,	s 1 and f Health item 27 other ti				Date		ity or Town, State
Ē	Pages nent of int: If it		1 - Danier 2 - Gordination 3 - Directional State	Litan Crematory 6/	11/05	Alexandi	ria, Virginia
Baltimore,	permit. Pages 1 Department of H important: If ite any injury or otl once.			22. Name and Address of Facility R			
D	20E 29		5kg.5ith	1405 Broomes Islan hter the mode of dying, such as cardiac	d Rd	Port Repu	ublic. MD 20676
			shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a.	cardial Info	retron		Orisot and Death
ľ	Examiner		Due to (or as a consequence of).	01.	- 1		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hotely Disec	se		
	cuted od ransit	Examine	that initiated events C.				
Ď,	e exe ian a		resulting in death) Last Due to (or as a consequence of):				
09/8	death certificate be executed e attending physician and of for use as the burial-transit	dicai	d				
ox e	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date	of delivery
ñ.	death s atter d for u	iciar	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date Monti	
5	the ache	hys	9 Unknown				
	og u	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
ecords	w require been signations beautiful to the state of the s	ted	Carcinana at bladder		10	Yes 2□No 3	Probably 4 Hinknown
Hec	e law has b le 2 sl	Completed	Horial Fibrillation.		24a. Was	s an 24b. We	ere autopsy findings available or to completion of cause of
			Systemic hypentension		1 ☐ Yes	ormed? de	ath? ☐Yes 2☐No
Vital	Physician: r this certific ral director,	o Be	25. Was case preferred to medical examination of the samination same of the same of	26. Place of Deal			
0	g Physe er this eral di	-	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		idence 6 Other	
201	tending later for: After the funer	atio	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office		(Street and Number wn, State)	or Rural Route Number,
	pital o		29a. Certifier 1☐ Ceptifying Physician: To the bast of my knowledge dea				
	24 ho 24 ho Fun etely 1	edical	29a. Certifier (Check only one) Captifying Physician: To the best of my knowledge, dea (Check only one) and manner stated.	In occurred at the time, date and place, rvestigation, in my opinion, death occur	, and due to the rred at the time,	cause(s) and mann date and place, an	ner as stated. Id due to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed ((Month, Day, Year)
			Kan and Il	717324		6/7/0	5
			30. Name and address operson who completed cause of death (Item 23a) (Type	, Print)		-110	
	4+1		Raymon A. Noble, M.D. 32 Cox Road, H. 31. Date filed (Month, Day, Year) 32. Registrates Signature	untingtown, Maryla	and 206	39	
	Sta Registr		JUN - 8 2005 Livered &	book			

		1 - For State Registrar	State of Maryla	•	artment of H				giene Reg. N2	005	21204
		1. Decedent's Name (First, Middle, La	st)				:	2. Date of De Month	ath Day	Year	3. Time of Death
	ician dical	Timothy Georg						June	11, 2	005	8:50 P M
1	niner	4a. Facility Name (If not institution, giv			4b. City, Town, or		of Death			ounty of Death	
		Anne Arundel Med 5. Social Security Number 6. S		rs. last birthday)	Annapol		r 24 Hrs.	8. Date of Bir		nne Art	
Funer Direct			QM 2□F 60		Months Days	Hours	Min.	B. Date of Bir (Month, Da May 17	y, Year) 194.	5 (nplace (State or Foreign untry) CA
		Usual Residence of Decedent	100	City, Town or Lo							10d. Inside City Limits
arylar show	5	MD 10b. County Anne Ar		Crofton	ocation						1 X Yes 2 □ No
the M	ecto	10e. Street and Number			10f, Zip Code				10g. Citize	en of What Co	untry?
3a of	Funeral Director	1432 Harwick Co	urt		21114				USA	A	
death	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of H	lispanic O	rigin? (Spec	ify Yes or No	- 14	Race - Amer Black, White	
15-0036 n 72 hours after death with the Marylan "natural", or Itams 23e or 28e-1 show	y Fu	1 Never Married 2 Married	1 □ Yes 2 □XNo If Yes, Give		1 ☐ Yes 2 ☐ No			,,		specify: Whi	
000. hours	ed by	3 Midowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occup	ation				of Business/	
115- in 72	plete	(Specify only highest gr		(Give	kind of work done of DO NOT use retired	during mo d)	st of working	9			ges County
21215-0036 sol within 72 hours att giene. er than "natural", or in Manicel Exerti	m _o	Elementary/Secondary (0-12)	College (1-40r 5+)	Retir	ed Firefi		_				
Taryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23e or 28e-f show reunsitic event, the Moulest Experience and the notified at	To Be Completed	17. Father's Name (First, Middle, Last)					(First, Middle,			
yla iould b i Ment	ပ	George Smith	T 0.44	10h Maili	ng Address (Street			a M. Ba			in Codo)
Maryland to 2 should be file this and Mental Hy to 18 marked eventhe	1	19a. Informant's Name/Relationship (George Smith/ Fa	** *		8 Shadow			ie, MD	207		ip Code)
re, l Tang Healt tam 2		20a. Method of Disposition		b. Place of Dispo		1	Da			ation - City or	Town, State
altimore, mil. Pages 1 ar portment of Hea portant: if item		1 ABurial 2 ☐ Cremation 3 ☐ 1 Donation 5 ☐ Other (Speci			coln Ceme		6/15	5/2005	Bre	ntwood,	MD
Baltimore, Maryland 212' permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiesm 27 is merked other than any Injury or other fraumatic event, 17° M	- Suce	21. Signature of Funeral Service Lice	nsee	2	2. Name and Addre	ss of Faci	lity Robe	ert E.	Evans	s Funer	al Home
0 285	a	1 Land			16000 Ann	-				MD 207	15 Approximate
33-20		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	eath. Do not en	ter the mode of dyli	ig, such a	s cardiac or	respiratory a	11654,		Interval Between Onset and Death
Pnysicio /Medic		disease or condition resulting in death)	a. Septic	S/no	ck,		- 17				
Examin	_		Gastv	ronte	stinal	He	21/10	rrha	DE.		
W	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	isequence of j.					J		
ocuted ind	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a con								
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and		Tosaking in doday Educ	Due to (or as a con	isequence oi).							
687 ifficate g physi	2 2		d								
Box 68 Box estifice statending ph	M/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	egnancy	∃Estania area nana				23	d. Date of deli	
O. B.	cla	in the past 12 months?	4 Pregnant at time		□Ectopic pregnancy □ Other (specify) _	y 				Month	Day Year
P.O. That the de by the defacthed	Phys	9 Unknown		Mar in Abra		in Dark		220 Dids	tobacco us	a contributa to	the cause of death?
IS, P Ires tha	ĝ.	Part II. Other significant conditions	A SC	t resulting in the t	indenying cause giv	7911 III Fait	. 1.	1 🗆	ــالا		obably 4 Dunknown
cord v require	eted	711001017101						24a. Was			topsy findings available
Rec Co	1 6							auto perfe	psy ormed?	prior to death?	completion of cause of
	0	25. Was case referred to medical				26. Plac	ce of Death	1 ☐ Yes (Check only o	2 Ж. No опе)	T Yes	2 No
of Vita Of Vita Physician:	ToB	examiner? 1 Tes 25 No	Hospital:	2 ER/Outpatie	nt 3 DOA Oth	ner: 4 🗆 N	lursing Hom	ie 5 ☐ Resi	idence 6	□Other (Spec	cify)
		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Wor	rk?		8d. Describe	how injury	occurred	
		2 Accident investigation 3 Suicide 6 Could not		A		Yes 2		of Location (Stroot and	Number or Pr	ral Route Number,
or Attance death of Director.	ertification:	4 Homicide determine		At nome, tarm, si pecify)	reet, factory, office		4	City or To		NUMBER OF AL	rai noute Number,
To the Hospital or Attanwithin 24 hours after death	a C		hysician: To the best of my	knowledge, dea	th occurred at the ti	me, date a	and place, a	nd due to the	cause(s) a	and manner as	stated.
he Ho n 24 h	edical	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	mination and/or i	rvestigation, in my o	opinion, de	eath occurre	d at the time,			
To the Within To the	X		α . Ω	1 A	29c. Licens					signed (Monti	
		Kller	ely U'.	jurde	MD D	000	0229	16	06	0/12	105
		30. Name and address of person who	A 1	(Item 23a) (Type	Print)	mila	101 111	ledim 1	Cont	er A	los nnapolis, UD
# # # # # # # # # # # # # # # # # # #	State	31. Date filed (Month, Day, Year)	32. Registrar's S			IV UV IC	ic M	CHULL	CCIII	0, 1	receptio, MD
Reg	gistrar	JUN 1 3	2005	· J.	Smiles						
DHMH 17 Re	v 1/2001						-				

ORIGINAL

Physician
/Medical
Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, It a Medical Expringer must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar		Otate of the	iai y tai i		tificate			Wichtairi	Reg. NO	000	
	Decedent's Name (First	st, Middle, Last)		0					2. Date of D	eath C	005	Ca. Time of Date
ian ical	Llewe	llyn	Lee	SWI	nsk	1			Month 06	O7	- 200	5 12:30 pm
ner	4a. Facility Name (If not in	institution, give si	reet and numbe	r)		4b. City, To	vn, or Lo	cation of Dea	th	4c.	County of Dea	th
	113 HAYN		DRIVE			CENT		lle		6	ucen	Anne
	5. Social Security Number 049–56–960		14 053 -	Age (In yrs. i	last birthday) Yrs.	If Under 1 \ Months D		Under 24 Hrs Hours Min		ay, Year)	C	thplace (State or Foreign ountry) XYLAND
	Usual Residence of Dece 10a. State 10b.	edent . County		10c. City	, Town or Lo	cation						10d. Inside City Limits
tor	MD GU	EEN ANNI	3	C	ENTREV	ILLE						1 ☐ Yes 2 X No
Director	10e. Street and Number					10f. Zip Co	de			10g. Citiz	zen of What Co	ountry?
a D	113 наума	KER DRIV	Æ			2	1617				USA	
Funeral	11. Marital Status		2. Was Deceder Armed Force	nt Ever in U. s?	S. 13. V	Was Deceden	of Hispa	anic Origin? (Specify Yes or N rto Rican, etc.)	0- 1	14. Race - Ame Black, Whit	
	1 Never Married		1 Yes 2 If Yes, Give Year or Dates			1 ☐ Yes 2 🖫		Specify:			Specify: W	•
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Be Completed by	17. Father's Name (First,	Middle, Last)					18		me (First, Middle	e, Maiden :	Sumame)	
P	DAVID EWEL								E ABEL			
	19a. Informant's Name/F)		-			iurai Route Numi ENTREVI I	-		
ŀ	20a. Method of Disposition		повыши	20b. P	lace of Dispo	sition (Name	of		Date		cation - City or	
	1 Burial 2X Cre		moval from Stat	8		natory or othe E CREM	,	N 6-	8-2005	STEV	ENSVILL	E, MD
	21. Signature of Funeral		Luc	CEN	TER 22 FE	. Name and A	ddress o	f Facility ENBEIN	& NEWNA	M FUI	NERAL B	IOME, P.A.
	23a. Part1. Enter the dis	sease, or complic	ations that caus	ed the death					CENTRI		E, MD 2	.1617 Approximate
	shock, or heart failu Immediate Cause (Final	ure. List only one	cause on each	line.							10	Interval Between Onset and Death
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/Me	IF FEMALE:	23	c. If yes, outcon	e of pregna	ncy					2	3d. Date of del	iven
ciar	23b. Was decedent preg in the past 12 mont 1 Yes 2 No	IIIaiii	1☐Live birth 4☐Pregnant	2 🗌 Fetal	death 3	Ectopic pregr Other (specif					Month	Day Year
Physician/	9 □ Unknown		9□ Unknown									
by P	Part II. Other significant	conditions cont	ributing to death	but not resu	ulting in the ur	nderlying caus	e given i	n Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
ted								1	1/2	Yes 2□	No 3□Pr	obably 4 Unknown
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Completed									perf 1 ☐ Yes	2 No	death? 1 ☐ Yes	_
Be	25. Was case referred to examiner?		spital:				Othor		ath (Check only	one)		
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tion		Pending investigation	28a. Date of In (Month, I	ay Year)	Injury	м 200.	Injury at Work? 1 Yes	2 🗆 No	EGG. DOGGNEG	now anguly	CCCBITEG	
ifica		Could not be determined	28e. Place of I	njury - At ho	me, farm, stre	eet, factory, of	fice		28f. Location	Street and	Number or Ru	ıral Route Number,
Cert	4 Homiciae		building,	etc." (Specily	"				City or 10	wn, State)		
Medical Certification:	29a. Certifier 1	Certifying Physi Medicel Exemin	cien: To the bes er: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred at ti restigation, in	ne time, o my opinio	date and place on, death occ	e, and due to the urred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
Me	29b. Signature and title of	certifier					cense nu			29d. Date	signed (Monti	h, Day, Year)
	> M.	Comer	rey 1	10		Do	05	917	3	6-	8-05	-
1	30. Name and address of				23a) (Type, I							
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registra's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Division of Vital Records, P.O. Box 68760

			Please	Type or Prir							le.	
	-	For State Registrar		State of Ma	aryland		artment of <i>tificate o</i> a	Health and N f Death				
		1. Decedent's Name (Fit	rst, Middle, L	ast)			imouto o	Dodin	2. Date of Dea	ath 20 (5	2 Time of Death
Physicia	เท			Strickland	1				Month	Day 300	Ger S	8.00.4M
/Medic Examine		4a. Facility Name (If not Doctors					4b. City, Town,	or Location of Death Lanham		4c. County o		George's
Funeral Director		5. Social Security Numb		Sex 7. Ag 1 ☐ M 2 ∏ F	e (In yrs. Ias 73		If Under 1 Yea Months Day		8. Date of Bird (Month, Da Mar • 9	, Year) 1932	9. Birth	place (State or Foreign Intry) Th Carolina
	-	Usual Residence of Dec	b. County		10c City	Town or Lo	cation					10d. Inside City Limits
Maryla f shov	ō	Maryland	•	e George's	, con only,			Heights				1 □Yes 2 □ No
with the	i Direc	10e. Street and Number	r		<u></u>		10f. Zip Code	20743		10g. Citizen of Wi		untry? States
w 0	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 Married	12. Was Decedent	Ever in U.S. No		Was Decedent of Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	pecify Yes or No Rican, etc.)	14. Race Black Specify:	White	^{ican Indian,} Frican merican
72 hou nature	ted		Decedent's	Education trade completed)		(Give	dent's Usual Occ	ne during most of worl	king	16b. Kind of Bus		
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "naturel", eny injury or other treumetic event, the Madical Exagnes.		19a. Informant's Name			_			etand Number or Ru e St., Cap				ip Code) 20743
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40200		23a. Part Enter the d	lisease, or co	mplications that cause	d the death.	Do not ent		nning Rd., lying, such as cardiac			200	Approximate Interval Between
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To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mg 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	pths?	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal o	death 3	∃Ectopic pregna ∃ Other (specify)			23d. Date Mon		very Day Year
ries that the signed by	by	Part II. Other significal	nt conditions	s contributing to death	but not resul	ting in the u	inderlying cause	given in Part I.			bute to	the cause of death?
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iding Physicien: The Ihe. After this certificate ha funeral director, page	1.1	27. Manne of Death 1 ☑Natural 2 ☐ Accident	5 Pending	28a. Date of Inj (Month, D.	lury lay Year)	28b. Time o Injury		njury at Vork? □ Yes 2 □ No	28d. Describe	how injury occurre	d	
or Atter after dea Director	Certification;		6 Could no determin	286. Place of it	njury - At h <i>o</i> r etc. <i>(Specify)</i>	ne, farm, st	reet, factory, offi	сө	28f. Location (City or To	Street and Numbe wn, State)	r or Ru	iral Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Medical C	29a. Certifier 1E (Check only 2E one)	Certifying Medical Ex	Physician: To the best caminer: On the basis and manner s	of examinati	vledge, dea on and/or in	th occurred at the	e time, date and place by opinion, death occu	e, and due to the urred at the time,	cause(s) and mar date and place, a	iner as nd due	stated. to the cause(s)
To th Withir To th	Me	29b. Signature and title	e of certifier	act to	au	al	M) 29c. Lic	0058	213	29d. Date signed 00 00 00	(Month	1, Day, Year)
MIO		30. Name and address	s of person wi	no complet a rouse of	death (Item	23a) (Type	, Print)	Present e	Witte A	Consins	281.	1, 40 20770
Sta	ate	31. Date filed (Month,	Day, Year)	A() M.O. 32. Regis	trar's Signat	ure (TA	NOVER	PKWY SU	11 211	Gree Cho		.,
Regist		JUN 1	3 2005	Server.	K	Soul	<i>y</i>					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 Physician JAMES E SMTTH June 8, 1:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Marlboro
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7507 Gambier Drive Prince Georges

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04–18–44 **Funeral ™** M 2 □ F 233-68-6610 61 Yrs. Director Charleston, WVA Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be notified at Yes 2 No Directo Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7507 Gambier Drive 238 20772 USA 12. Was Decedent Ever in U.S. Amed Forces? 1

Yes 2 □ No If Yes, Give Year or Dates: 1967–69 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ba filed within 72 hours after dital Hygiene. die Othar then "naturel", or item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž**O**No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Dept. of Defense College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should ba fi and Mental H is marked ot James Freeman Helen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If ilem 27 is m eny Injury or other treum once. Jerome Caldwell / Personal Rep. 12210 McCullagh Ct., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery 06-15-05 Cheltenham, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services, P.A 21. Signature of Funeral Service ice ise 6500 Allentown Road, Camp Springs, MD 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical luir disease Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): the attending physician and shed for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA el or Attending Ph s after death. si Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funerei D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Withutcheson, MI completed cause of death (Item 23a) (Type, Print) CAMP SPANGS, Mediculcente, 6104 Francis 31 DN file (30n/2005 Year) State Registrar

Chester Slaughter Jr. 05-3861

AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Security Security Security	н			Chester	Slaughter.	.Ir.			June 5.		11.03 P
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The course The		Funeral		Social Security Number 6. S	7. Age (/	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
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22. Name and Address of Facility 3538 NaT1DS: P PRE Emeral Homes, M. A. 20747 23. Signatify of Function Simple Upgrase 24. Signatify of Function Simple Upgrase 25. Signatify of Function Simple Upgrase 26. Signatify of Function Simple Upgrase 27. Signatify of Function Simple Upgrase 28. Signatify of Function Simple Upgrase 29. Signatify of Function Simple Upgrase	J.	othe			1	20b. Place of Dispo	sition (Name of	ce)			
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27. Manner of Death 28a. Date of Injury 28b. Time of Injury	ita	strifica ctor,	0					26. Place of Deat			
1 Natural 2 Accident 3 Suicide 4 Homicide Substitution	<u>\$</u>	hysic nis ce I dire			Hospital: 1 ☐ Inpatient	2 XER/Outpatier	nt 3□ DOA Oth	er: 4 🗌 Nursing Ho	ome 5 Reside	ence 6 Other	(Specify)
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June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005 June 6, 2005		the h in 24 the F iplete	ledi	one)	and manner stated	d.					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkly E Sauthai) m) 31. Date like (Month, Day, Year) 32. Registrar's Signature		or with the state of the state	2	29b. Signature and title of certifier						_	• • • • • • • • • • • • • • • • • • • •
Pamelu E. Satthai, M) III Penn Street Baltimore, Maryland 21201		XII)		Yanete Forth	ell, MD		UC	T.IC		oune o,	ZUU)
31. Date liled (Month, Day, Year) 32. Registrar's Signature		Cir	+			h (Item 23a) (Type,	Print)	Stroot	Doll-i-	M	Jand 21201
State 31. Date liled (Month, Pay, Year) 32. Registrar's Signature		ر مر					TIT Petili	street	Dalt111101	le, Mary	Tand ZIZUI
Registrar JUN 1 3 2003				31. Date liled (Month, Day, Year)	32. Registrar's	Signature					

			1 - For State Registrar	State of Maryland	d / Depa			Mental Hygi	_		21:	210
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month)	Year	3. Time of	
	/Medi Examir		Sophia A. Sade 4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death	June	Day 13,	2005	8:00	РМ
	LAdiiii	ici	99 Mt. Royal Aver				erdeen		Harf			
	Funeral Director		5. Social Security Number 6. Sex 065-03-0717	7. Age (In yrs. le		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/01/1	Ye <i>ar)</i> 909	9. Birthpla Countr Penns	ice (State or y) Sylvan	rForeign nia
	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show diest Exsorter must be notified at		10a. State 10b. County	10c. City	Town or Lo	cation				100	d. Inside Cit	
	be filed within 72 hours after death with the Manylan Ital Hygiene. sd other then "neturel", or Items 23s or 28s-f show event, Ira M. Jical Exertinat must be notified at	Funeral Director	MD Harford	A A	berdee						1 Yes	2 No
	3a or	iDi	99 Mt. Royal Aver	210		10f. Zip Code 21 C	001	10	g. Citizen of V U.S.A		y?	
	death	nera		12. Was Decedent Ever in U.S Armed Forces?	S. 13. V		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Rac	e - America		
36	s after , or Ite	by Fu	1 Never Married 2 Married	1 ∐Yes 2 ŽNo If Yes, Give	- 1	☐ Yes 2 No		Hican, etc.)	Specify	ck, White, et	c.	
8	2 hour		3 XWidowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a, Deced	ent's Usual Occup	pation	11	6b. Kind of Bu	Whit		
212	within 72 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work done OO NOT use retire	during most of world)	king	ob. King of Bi	33111033/11100	Sily	
Maryland 21215-0036	e filed within al Hygiene. I other then '		12 17. Father's Name (First, Middle, Last)	Õ	H	lomemaker		(5)	Home			
anc	d be fi	To Be	Adam Sudol				18. Mother's Nam Frances	e (First, Middle, M.	aiden Surnam	10)		
ary	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked of any injury or other treumatic events.	F	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailin	g Address (Street	and Number or Ru		City or Town,	State, Zip C	ode)	
	and 2 ealth a m 27 Is		Frances A. Kateley		99 Mt	. Royal	Ave., Abe	erdeen, M	arylan	d 2100)1	
Jore	ages 1 t of H : If ite or ott		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Reference Burial 2 □ Cremation 3 □ Reference Burial 2 □ Cremation 3 □ Reference Burial 2 □ Cremation 3 □ Reference Burial 2 □ Cremation 3 □ Reference Burial 2 □ Cremation 3 □ Reference Burial 3 □	dinoval floid State		sition (Name of natory or other place			Dc. Location -	City or Tow	n, State	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		'4 □Donation 5 □ Other (Specify) 21 ♣ Indure of Funeral Service License		+		lens 06/18		berdee	n, Mar	yland	<u> </u>
ä	Depa Depa Impo any ir		Mara C, 2	ellman	33	rring-Ca 3 South	rgo Funer Parke Str	cal Home, ceet, Abe	P.A. rdeen.	MD 21	001	
8760,	And particular and particular and particular and the burial-transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	lan C	newor	va			nterval Betwo	
.O. Box 6	ath certific ttending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3□	Ectopic pregnancy Other (specify)	,		23d. Date Mor	e of delivery		ear
Records, P.	quires that the de in signed by the a uld be detached t	by	Part II. Other significant conditions con	tributing to death but not result	ting in the un	derlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	1 -		cause of dea	
eco	e law requir has been si je 2 should	Completed						24a. Was an autopsy			y findings av	
a B								performe	d? d	eath?	□ No	
Vita	ysicien: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?	ospital:	R/Outpatient	3 DOA Oth		h Check only one)				
ion of	ding Ph h. After th funeral	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injur	4 🗆 I tali Sili g i i c	me 5 A Resident 28d. Describe how				
Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	or Or Rural R	oute Numbe	er,
	To the Hospitel or Attenwihin 24 hours after deatl To the Funerel Director:	edicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	ician: To the best of my knowler: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tine stigation, in my o	ne, date and place, pinion, death occuri	and due to the cau red at the time, date	se(s) and mar a and place, a	nner as state nd due to th	e cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of senther	11119		29c. Licenso	e number	290	Date signed	(Month, Da	y, Year)	
	Н		304 Name and address of person who con	noleted cause obdoorb (lice 5	Pal /Tuna 5	U3(116	U	2114			
	1		CHINCLESS EG	npleted cause ondeath (Item 2	W BE	ECHEIR	KUT-	HOECH)	12HA 1	(MD)	, 211	001
* :	Sta Registr		31. Date filed (Month, Pay, Year) JUN 15 200	32. v egistrar's Signatu	ro	ed .		0000	0.01	V V		-

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** /Medical David Thomas Staley June 9, 2005 10:00 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Nursing & Rehab. Center Westminster
If Under 1 Year If Under 24 Hrs. Carrol1 **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊊**M 2□F Days Min Director 219-60-4936 Usual Residence of Decedent Sept 23, 1952 Maryland with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f ehov traumatic event, Ite Medical Examiner must be notified at 1√2 Yes 2 □ No Director Maryland
10e. Street and Numbe Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 226 Timber Grove Rd. 21136 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No à Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. important: if Itam 27 is marked other than "na any injury or other traumatic evant, Ita Madis once. The Whiting-Turner Elementary/Secondary (0-12) College (1-4or 5+) Contracting Company 12 Steamfitter & Superintendant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wolford McDonald Staley Margaret Catherine Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene P. Staley Wife 226 Timber Grove Rd. Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 6/10/05 Hampstead, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit 200 Due to (or as a consequence of): physician Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ eq 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificate 1 Yes 2 🗆 No Division of Vital 1 Yes 2 🗔 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Natsing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗓 🛶 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) MJI -0054-218 x 12 Name and address of person w ess of person who completed cause of death (Item 23a) (Type, Print) Westminter MD 21157 Malcalm dury aneus 32. Registrar's Signature State Blown & Sports Registrar

			1 - State of Maryland /	Department of Health and Me Certificate of Death	ntal Hygiene Reg. No. 2005 21212
	Physici /Medic		Decedent's Name (First, Middle, Last) GUERNIE RICHA	ARD STULLER	Date of Death Day Year JUNE 4, 2005 9:45 p M
	Examir	er	4a. Facility Name (If not institution, give street and number) CARROLL LUTHERAN VILLAGE 5. Social Security Number 6. Sex 7. Age (In yrs. last bi	4b. City, Town, or Location of Death WESTMINSTER inthday) If Under 1 Year If Under 24 Hrs. 8	4c. County of Death CARROLL Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		218-14-1335	Yrs. Months Days Hours Min. 1	1/12/1923 MARYLAND
	the Maryla 28e-f shov	rector		wn or Location STMINSTER 10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 27 No 10g. Citizen of What Country?
98	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28e-1 show or other treumetic event, the Medical Examinar must be multilised at	by Funeral Director	140 FEDERAL ANN LANE 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes. Give	21157 13. Was Decedent of Hispanic Origin? (Specifi f Yes, specify Cuban, Mexican, Puerto Ric	USA
21215-0036	within 72 hours iene. 'than "natural" itts Medical Ex	Completed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESMAN	16b. Kind of Business/Industry CARS
Maryland 2	I 2 should be filed within and Mental Hygiene. Fis marked other than "reumatic event, the Mac	To Be Co	17. Father's Name (First, Middle, Last) GUERNIE LOWNDES ST	18. Mother's Name (F	First, Middle, Maiden Surname)
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Importent: if Item 27 is m any injury or other treum <u>once.</u>		BETTY J. STULLER - WIFE 14 20a. Method of Disposition 3 Removal from State 20b. Place of Comments	b. Mailing Address (Street and Number or Rural Fig. 10 FEDERAL ANN LANE of Disposition (Name of ery, crematory or other place) MES CEMETERY 6/9/0	, WESTMINSTER, MD. 21157 20c. Location - City or Town, State
Baltir	permit. P Departme importen any injur		21 Signature of America Licensee	i · ·	CHER FUNERAL HOME
8760,	The law requires that the death certificate be executed by Manager 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the Iseases or complications that caused the death. Do shock, or heart failured its control in the cause of the cause	BLADDER CA o of): o of):	espiratory arrest, Approximate Interval Between Onset and Death 1 yr
.O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year
ords, P.	v requires that been signed b should be dete	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒No 3 ☐ Probably 4 ☐ Unknown
al Records,		Completed			24a. Was an autopsy performed? 1 ☐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
sion of Vital	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	ation; To Be	1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation		Check only one) 5 Residence 6 Other (Specify) 1. Describe how injury occurred
Division	pitei or Atturs after de srei Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
	WIL	Medical	29a. Certifier (Check of V) 2 Medical Examiner: On the basis of my knowledg (Check of V) 29b. Signature and title of certifier 30. Name are address of person who completed cause of death (Item 23a)	29c. License number D35398	at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	Sta		FLAVIO KRUTER MD 555 S. (31. Date filed (Month, Day, Year) 32. Registrar's Signature	CENTER ST., WESTMINS	TER, MD. 21157
	Registi	ar	JUN 0 9 2005 Leave 1	7 Braile	

			1 - For State Registrar	State of M	larylan		artment of H		and Mental Hy	•	2.0.10
ш	Dhusisi		1. Decedent's Name (First, Middle, La	st)					2. Date of De		
	Physici /Medio			afer					JUNE	12, Day 2005	1:57 P M
	Examin	er	4a. Facility Name (If not institution, give 20 APPLES CHURCH	RD			4b. City, Town, o THURMO	NT		4c. County FREDI	of Death ERICK CO
	Funeral Director		212-50-///1	ex 7. A □ M 2⊠ F	ge (In yrs. 56	last birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	24 Hrs. 8. Date of Bi Min. (Month, Da June 2	rth ay, Year) 7, 1948	9. Birthplace (State or Foreign Country) Maryland
6	W #		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
9	-1 sh	ŏ	Maryland Frederic	r.k		Thurmo	nn t				1 ⊠ Yes 2 □ No
, 1	r 28a	Directo	10e. Street and Number			THUTIN	10f. Zip Code			10g. Citizen of V	Vhat Country?
Ť.	23a c		20 Apples Church	n Road			21788	}		Unite	d States
0	lams	Funerai	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U	.S. 13. \	Was Decedent of H	lispanic Orig	gin? (Specify Yes or No., Puerto Rican, etc.)	o- 14. Rac	e - American Indian, k, White, etc.
တ္တ	Or ii	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give			I□Yes 2⊠No		, , , , , , , , , , , , , , , , , , , ,		: White
d 21215-0036	should be been with 7 k hours and bean with the wayran marked other Hygiene. marked other than "natural", or itams 23a or 28a-1 show imatic evant, the Medical Exactiner must be notified at	edb	15. Decedent's Ed	Year or Dates fucation		16a, Decec	ient's Usual Occup	ation			usiness/Industry
212 213	u di	piet	(Specify only highest gra	de completed) College (1-4o		(Give	kind of work done DO NOT use retired	durina most	t of working	100. Killa of Be	isinessindustry
Maryland 21215-0036	giene giene er the	Completed	12	College (1-40)	3+)	Seci	retary			Pavi	ng Company
ם פ	al Hy d other	Be	17. Father's Name (First, Middle, Last)					18. Mothe	or's Name (First, Middle		
aryla	Ment	L _O	Reno Linton						garet Snool		
-	1 0 m		19a. Informant's Name/Relationship (er or Rural Route Numb		
e, -	Health tam 27 othar tr		Preston Shafer /	Husband	20h F		oles Chur		ad Thurmon		land 21788
Baltimore,	in it of the company		1 ⊠Burial 2 ☐ Cremation 3 ☐		7		sition (Name of natory or other place		June 17,		City or Town, State
֓֞֞֜֜֟֓֓֓֓֓֟֜֟֓֓֓֓֓֟֓֓֓֟֟֓֓֓֓֟֟	artme ortant injury	,	*4 □Donation 5 □ Other (Specify 21. Signature of Foneral Service Licer		Res		Mem. Ga:		2005	Frederic	k, Maryland
Ba	permit: rages I are Department of Heal Important: If itam 2 any injury or othar 20058.			-		10	4 E. Mai	n Stre	'Stauffer Pet Thurmo	Funeral nt Mary	Homes, P.A. land 21788
			23a. Part1. Enter the disease, or com	plications that cause	d the deat						Approximate Interval Between
1	ilysi ci ali	1	shock, or heart fallure. List only Immediate Cause (Final			coties	Pardie	Jacie	was Dise		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a			Cavallo	Vasce	wal 17156	ase	
E	xaminer		Sequentially list conditions	h							
7	2 %	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	uence of):					
4100	and -trans	Examiner	that initiated events resulting in death) Last	C							
8760,	ohysician and the burial-transit	aiE		Due to (or a	s a conseq	uence or).					
789	phys s the	edicai		d							
Records, P.O. Box 68/60,	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna					23d Dat	e of delivery
ă	a atte	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pregnancy Other (s <i>pecify)</i>	′		Mor	,
J.	by the a	hys	9 XUnknown	9□ Unknown							
S, T	igned be det	by P	Part II. Dther significant conditions c		but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	tobacco use contr	ibute to the cause of death?
ord	been si	ted	Viahetes Welli	tus					1	Yes 2 No	3 Probably 4 □Unknown
Records,	as be	Completed							24a. Was	nsv n	Vere autopsy findings available
		Co							perfo	ormed? d	eath? XYes 2□ No
Vital	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			0#		of Death (Check only		
O	this ral dir	L.	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpat		ER/Outpatien 28b. Time of		4 🗀 NUI	rsing Home 5 Resi		
DIVISION	After funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2∐N		how injury occurr	90
VISI	r death.	ifica	3 ☐ Suicide 6 ☐ Could not be		njury - At ho	ome, farm, stre	eet, factory, office		28f. Location (Street and Number	er or Rural Route Number,
בֿ בֿ	s afte	Certification;	4 Homicide determined	building, e	tc. (Specif	y)	· ·		City or To	wn, State)	
DIVISION OF VITA	within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical (29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examina	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and pinion, deat	d place, and due to the th occurred at the time,	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
40 4	withir To th comp	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date signed	(Month, Day, Year)
			· Carde Ha	llan	nd		OCM	E		JUNE 13	, 2005
1	2		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type, I					
10000	*****	2,1	CAROL HAZ	CAN W	d		111 P	enn St	treet Balt	imore, M	Maryland 21201
	Sta		31. Date filed (Month, Day, Year)	7005 32. Fi gis	trar's Signa	ture	Lake				-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Linda Chesnel Santoro 2005 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3057 Mimon Road Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 🕏 F 046-30-8532 65 Yrs. Director 1939 Maine Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsms 23a or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1 Yes 20 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3057 Mimon Road 21403 U.S.A. filed within 72 hours after deeth Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 25No If Yes, Give Year or Dates: al Hygiene. Specify: White 1 ☐ Yes 2 XNo ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Heelth end Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event QDCS. Be Joseph E. Chesnel Helen G. Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ralph Santoro/husband 3057 Mimon Road Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2000 remation 3 ☐ Removal from State Baltimore Crematory 6/12/2005 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute myelogenous **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed use as the burial-transit ettending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ete has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. escribe how injury occurred 27. Manner of Death of or Attending Feffer death. After Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospitel of within 24 hours el To the Funeral D Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartillar Medical (Check only one) 29b. Signature and title of certifier 29c. License number D52830

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

900 Bestgate Road #300 Annapolis MD

Hanne Weine, M12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Egune Werner, MD

31. Date filed (Month, Day, Year)

and Mental Hygiene

For State Registrer Certificate of De
State Conditions of D.

2. Date of Death 2 A

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mudical Examples.

> Physician /Medical **Examiner**

> > attending physician and for use as the burial-transit After after death Director: the

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Medical

June 3 2005 Thomas Christopher Truitt 4a. Facility Name (If not institution, give street and number)
1918 Constitution Drive 4c. County of Death 4b. City, Town, or Location of Death St. Leonard Calvert 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 43 | Yrs. | Months | Days | Hours | Min. | July 9 1961 5. Social Security Number 577-94-5991 6. Sex 9. Birthplace (State or Foreign 1**∑**M 2□F Washington D Usual Residence of Decedent 10a. State Maryland Calvert 10c. City, Town or Location 10d. Inside City Limits St. Leonard 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1918 Constitution Drive 20685 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 police officer metro transit Father's Name *(First, Middle, Last)* lax Truitt 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathe Max Elizabeth Castleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen McCurry-POA 1918 Constitution Dr. St. Leonard MD 20685 20b. Place of Disposition (Name of 3^{Date}2005 Home 20a. Method of Disposition 20c. Location - City or Town, State Committee, cremajory or other place) June Metropolitan Funeral 1 Burial 2 Cremation 3 Removal from State Alexandria Virginia * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home 4405 Broomes Island Road Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. A proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bladder cancer Gall Several months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

ID

State Registrar

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Charles Bennett MD H.G. Trueman Rd. ILLsby Maryland 20657 31. Date filed (Month, Day, Year) 32. Re JUN - 8 2005 32. Registras Signature

harles W. Bennett M.) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Berow & Sparte

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

125156

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health a State of Maryland / Department of Health a 6/15/05ertificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** June 2005 5:33 Patrick Conner Wilbourne Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick Frederick Memorial Hospital 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Director February 26,1948 North Carolina -78-Usual Residence of Decedent tha Maryland 10h County 10c. City Town or Location 10d. Inside City Limits 10a State 27 is marked other than "neturel", or Itams 23e or 28e-1 ebov traumatic event, the Madical Examinar institut and 1 Yes 2 No Frederick Frederick Director Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21702 U.S.A. 6095 Fountain Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11 Marital Status i and 2 should ba filed within 72 hours after of teath and Mental Hygiene. Health and Mental Hygiene. Im 27 is marked other than "neturel", or Itan 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Specify: White þ tf Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paving Owner paving Company 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Patrick Conner Wilbourne, Sr. Helen Maxine Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai <u>once.</u> Janet Wilbourne - wife 6095 Fountain Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/10/2005 Resthaven Memorial Frederick, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Ocensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death Myocardial Infanchas Immediate Cause (Final 12 hrs. Priysician Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, my Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760 physicien Physician/Medical as the b IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No Probably 4 Unknown Tistast Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 → Mo 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending PI 24 hours after death. e Funeral Director: After th 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the I within 2-29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title a certifier 8, 2005 TUNE 0-57796

Registrar

State

400 West Seventh Street, Frederick, Maryland

21701

address of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

ERMA

1 5 2005

LAL17

31. Date filed (Month

		ļ	For State	State of M	laryland / Depa	artment of H					
			Registrar 1. Decedent's Name (First, Middle, La	st)	061	tillcate of	Dealli	2. Date of Deat	eg. No. 2 (105	3/Time of Death
	Physici		DAVID THOMAS	WHITN	EΥ			June	Day	Year	11130 M
	/Medic Examin		4a Facility Name (If not institution, giv			4b. City, Town	r Location of Death		4c. County	799	1420
			Peninsula Regio	nal Men	ical Center	Sa	Isbury		Wich	mice	J .
	Funeral			ex 7. A	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Mrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthple Count	ece (State or Foreign
	Director		220-28-4350 Usuel Residence of Decedent	JAIN 201	77 Yrs.			April 8,	1928	Maryl	
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10	d. Inside City Limits
	Mary Fed	ţō	Maryland Wicomic	0	Eden						1 ☐ Yes 2 🙀 No
	h the	lrec	10e. Street and Number		Haon	10f. Zip Code		1	0g. Citizen of	What Count	ry?
	23a c	alD	25958 Walnut Tree	Road		21822				USA	
	tems	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
36	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f show he Madical Eventrel must be notified at	by Fi	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dayes	410-40	1 ☐ Yes 2 🖰 No	Specity:		Specif		
8	e hou		15. Decedent's E	ducation		dent's Usual Occup	ation		16b. Kind of B	Black	
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nd	be filed tal Hygid d other avent, t	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	Maiden Suman	ne)	
yla	2 should be and Mental is marked o	၉	Edward Whitney				Bernadin	0 - 1 :			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. itam 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic avent. The Medical Exemplest mast be natified at		19a. Informant's Name/Relationship (-	and Number or Rui				
	1 and Healt am 2	1	Ruth W. Belle/ auni 20a. Method of Disposition	ţ	20b. Place of Dispo		Street - I		e1awar∈ 20c. Location -		
nor	ages ant of t: If it		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif			natory or other plac	:e)				
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If itam 27 is any injury or other tra	1	21. Signature : Funeral Service Licer						Hurlock Road -	, Mai - Salis	bury, MD
ä	permi Depa Impo any ii		Derette 1	5. X2110			MORIAL	_	1	0 4 2 1 5	21801
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	/Medical		resulting in death)	Due to (or a	s a consequence of):	Con Co O	20101001	,			
	Examiner	_	Sequentially list conditions,	b							
	ed sit	Examiner	Sequentially list conditions, I any leading to in-mediate cause. Enter Underlying Cause (Disease or injury	Mas ac for an	s a nonsequanna of):						
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8760,	cate be executed physician and the burial-transit	dlcal		d							
9	ifficati g phy as the	edic		_ u							
Вох	death certifi e attending p id for use as	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy				te of deliver	-
	that the death certificed by the attending podetached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)			Mo	nth [Jáy Year
P.O.	at the	Phy	9 Unknown					00- 014-1			
	es ngi pe	by	Part II. Other significant conditions	contributing to death	but not resulting in the ur	nderlying cause give	en in Part I.		s 2 No	ribute to the 3 □ Probal	cause of death?
Ö	v requir been s should	etec									
Records,	The law ate has page 2 s	Completed			<u> </u>			24a. Was ar autopsy perform	/	orior to com- death?	sy findings available pletion of cause of
Vital		e Co	25. Was case referred to medical				00 Plans of Dant			I□Yes 2	□ No
Ē	Physician: r this certificaral director,	OB	examiner?	Hospital: 1 ☐Inpat	ient 2 ER/Outpatien	t 3 DOA Othe	er: 4 Nursing Ho	h <i>(Check only one</i> ome 5 □ Beside		er (Specify)	
o L		n: T	27. Manner of Death	28a. Date of Inj (Month, D.	ury 28b. Time of		at	28d. Describe ho			
io	Attanding r death. actor: Afte	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	n i	ay roary injury		Yes 2 No				
Division	or Attand after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of In	ijury - At home, farm, stre tc. (Specify)	eet, factory, office		28f. Location (Str City or Town		er or Rural i	Route Number,
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	Hosi 24 ho Funa Funa stely f	edical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exar	riner: On the basis and manner s	t of my knowledge, death of examination and/or inv	occurred at the time restigation, in my of	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and ma ite and place, :	inner as stat and due to t	led. he cause(s)
	To tha Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	Mec	29b. Signature and title of certifie			29c. License	number	29	d. Date signer	d (Month, Di	ay, Year)
	->-0		> ununt (so	wille	- OUM	D5	2014		6/13/03		
	4		30. Name and address of person who MAM ESM MO	completed cause of	death (Item 23a) (Type,	Print)	250				10.00
	1		MANESH MO	and voi	186 MILES	vd st s	0435	Alls BL	iny as	1/2 21	804
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	Registr	ar	1 2	UUJ JOSEL	w B. Co						

DHMH 17 Rev 1/2001

David Whitney

JET05-04003 Robert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

rt	C. WII	SO	For State Amendment item#8,QACHD,6/22/05,tw Cell Registrar	rtificate of Death		
			Decedent's Name (First, Middle, Last)		2. Date of Death	1. N2 0 0 5 2 1 2 1 8
	Physici		ROBERT C. WILSON		Month June	Day Year 10:30 A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Juic	4c. County of Oeath
			Anne Arundel Medical Center	Annapolis		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Y	
	Director		216-44-6398 ¹ X M 2□F 59 Yrs.	Months Days Hours Min.	DR 3	1946 MA
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Lc		lay 3, 1946	
	aryla shor	5		cation		10d. Inside City Limits
	he M	Director	MD QUEEN ANNE'S CHESTER			1 ☐ Yes 2 🛣 No
	with t	급	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
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	ter d	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 ▼ Married 12. Was Decedent Ever in U.S. 13. \ Amed Forces? 1 ▼ Yes 2 □ No 1965—	Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
39	ours after death with the Marylan ral', or Items 23a or 28a-f show Examinar must be notified at	by F		1 ☐ Yes 2 X No Specify:		Specify: WHITE
Maryland 21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Acal Examiner must be notified at	ted	15. Decedent's Education 16a. Decedent	dent's Usual Occupation	16	b. Kind of Business/Industry
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밀	be filed Ital Hygi d other event.	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (
Na		ှ	CHARLES ROBERT WILSON	AGNES CUR	RY	
a	2 sho and is mu		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rural I	Route Number, C	ity or Town, State, Zip Code)
	r 2 Filed			LOGAN COURT, CHESTE	R, MD 2	21619
ore	m O		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition	natory or other place)	te 200	c. Location - City or Town, State
Ξ.	Pages ment of I ant: If its lury or o		`4 □Donation 5 □Other (Specify) CHESAPEAR CENTER, L	E CREMATION 06/16/	/2005 S	TEVENSVILLE, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Futheral Service Licensee / () / 22	. Name and Address of Facility		FUNERAL HOME, P.A.
_	20 = 4 Q			O SHAMKUUK KUAD, C	HESTER.	MD 21619
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or r	respiratory arrest,	Interval Between
ng ri	Physician		Immediate Cause (Final disease or condition condition and the condition cond	atheroscleratic	-Gardio	V.SC and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		_	Sequentially list conditions, b.			
	led Isit	ulue	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events			
•	certificate be executed iding physician and ise as the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
68760,	be e siciar buri					
687	ficate g phy-	Medical	0.			301 301 301
×	S G C		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Bo	death ce	cia	in the past 12 months?	Ectopic pregnancy Other (specify)		Month Day Year
0	The law requires that the death the has been signed by the atternage 2 should be detached for u	Physician/	9 Unknown			
S, D	res tha igned be del	by P	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ğ	w require been sig	ba			1 🗌 Yes	2 No 3 Probably 4 Unknown
Vital Record	e law re has be je 2 sh	Completed			24a. Was an	24b. Were autopsy findings available
Ě		E O			autopsy performed 1 Yes 2	
Ita	ysician: This certificate director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (C		10 2010
	S S	2	1 XYes 2 ☐ No Hospital: 1 ☐ Inpatient 2 X ER/Outpatient	3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)
0	ding Ph. After thi funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		d. Describe how in	
<u>S</u>	Attending r death. ector: After by the funer	cati	2 Accident investigation	M 1 Yes 2 No		
Division of	or Attence after death Director:	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, stre building, etc. (Specify)	et, factory, office 28f	Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	Hospital or Attanc 24 hours after death Funeral Director: tely filled in by the t	O				
	Hos 24 ho Fune stely f	Medical	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, death (Check only one) 2▼ Medical Examiner: On the basis of examination and/or invegor	occurred at the time, date and place, and estigation, in my opinion, death occurred	due to the cause at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Me	29b. Signature and title of centiler	29c. License number		Date signed (Month, Day, Year)
	- s - ö	13	Dt - Comics - DMO	OCME	_	
	. N	1	3D. Jame and address of person who completed carse of death (Item 23a) (Type, P	Print)	Jun	ne 12 2005
)/U		Fatericia Armica - Pollak MA		Baltimo	re, Maryland 21201
	Stat	e	31. Date filed (Month, Day Year) 32. Regist ar's Signature	4		,
	Registra	ar	JUN 1 4 2005 Bleeve &	Sperte		

			State of Maryl		artment of He		lental Hygie	ene	
			Registrar 1. Decedent's Name (First, Middle, Last)	061	runcate of D	Calli	2. Date of Death	2005	3 Timent Death
	Physicia	an	Jeannine Louise Wheeler				Month	Day Year	M. M.
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	June 16	5, 2005 4c. County of Dea	1:00 P
1	Examin			02	Fredrick				
J	Funeral		6512 Spring Water Court # 42 5. Social Security Number 6. Sex 7. Age (In)	vrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Fredrick 9. Bir	thplace (State or Foreign
0	Director		219-42-4385 1□M 2♥F	61 Yrs.	Months Days	Hours Min.	(Month, Day,) Dec. 17,	1943 Mar	yland
	PL ,		Usual Residence of Decedent	-					
	shov	_		City, Town or Lo	Frederic	7			10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	ecto							
	within 72 hours after death with the Maryland ane. than 'natural', or items 23a or 28a-f show na Madical Examiner must be nutified at	Funeral Director	10e. Street and Number 6512 Spring Water Court #420	3	10f. Zip Code	21701		g. Citizen of What Co United St	
	eath	erai	11 Marital Status 12 Was Decedent Ever		Was Decedent of His	nanic Origin? (Spe		14. Race - Ame	
	fter d r item	듄	Armed Forces?		Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ XNo	Specify:		Specify:	White
9-0	72 hours "natural", dical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupat	ion wing most of worki	16	Bb. Kind of Business	/Industry
21	ithin ithin	npie	Elementary/Secondary (0-12) College (1-4or 5+)	1	kind of work done du DO NOT use retired)		, ·g		
7	ygier ygier yer th	So	12	Cont	ract Spec			Governm	ent
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last)				<i>(First, Middle, Ma</i> thy Stark		
<u>\Z</u>	d Mer d Mer narke	은	John L. Wheeler	401 14 75					T. O. (.)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "in any injury or other traumatic event, In a Median once.		19a. Informant's Name/Relationship (Type, Print) William Whitmore / Son	8600	ng Address <i>(Street an</i> Imaginatio	on Court	, Walkers	ville, MD	21793
	1 and Healt em 2 ither	Н		b. Place of Dispo	osition (Name of	! 0		c. Location - City or	
Baltimore,	ages int of t: if it		1 Rurial 2 Terremation 3 Permoval from State	cemetery, crei	matory or other place; c Crematory				Maryland
臣	artme ortani injury	Ť	21. Signay(i)e of Funeral Service Licensee	22	2. Name and Address				
Ba	permi Depa impo any i		Marcha D. Stanlar		1621 Opos	sumtown I	Pike, Fre	derick, M	D 21702
			23a Part. Enter the disease or complications that caused the c shock, or heart failure. List only one cause of each line.	leeth. Do not ent	ter the mode of dying,	such as cardiac o	or respiratory arres	t,	Approximate
	Physician		Immediate Cause (Final						Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Carbamazept Due to (or as a con		OXICALION				
Н	Examiner	Ì							
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):			_		
	te be executed ysician and ne burial-transit	Examiner	that initiated events c.						
760,	ite be exe iysician a ne burial-		resulting in death) Last Due to (or as a con	sequence of):					
876	± ≥ 5	licai	d						
x 68	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:						
Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of prediction in the past 12 months? 4 Pregnant at time	etal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	that the de ed by the a detached f	ysic	1 ☐ Yes 2 No 4☐ Fregrant at time 9 ☐ Unknown 9 ☐ Unknown	orugati 5L	Other (specify)	-			
۵.	The taw requires that the death certifics ate has been signed by the attending phage 2 should be detached for use as t	F	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause giver	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds.	uires n sign	d by					1 🗌 Yes	2 □ No 3 □ P	robably 4 Únknown
000	s been should	jete					24a. Was an	24b. Were a	utopsy findings available
Vital Records,	sicien: The taw certificate has t irector, page 2 s	Completed				<u> </u>	autopsy	prior to death? No 1207es	completion of cause of
ta		O	25. Was case referred to medical			26. Place of Death	1 (Check only one)	1140	20110
	> 00	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Other	4 Nursing Hor	me 5 Residen	ce 6 XOther (Spe	city) scene
0 0	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 6-1 600 5 ay Yea	28b. Time o 11 125		at 2	28d. Describe how		
. <u>Ö</u>	Attending ir death. ector; After by the fune	atic	2 Accident Investigation found	found	M 1□Ye	es 2X No S	-	ngested d	_
Division of	ei or Attendii s after death. I Director: A d in by the fu	Certification;	Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (Sp.	At home, farm, str ecify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State) 6512 S	ural Route Number, pring Water ryland
	rs af	Ce	residence						
	To the Hospitei or within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my (Check only one) 2 ☐ Medical Examiner: On the basis of examiner and manner stated.	knowledge, deat nination and/or in	h occurred at the time vestigation, in my opi	n, date and place, a nion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and titlg of certifier		29c. License	number	290	I. Date signed (Mont	h, Day, Year)
	⊢≯⊢ŏ		VT/ 11/1/10		OCM	E	-	477 00	0.5
			30. Name and address of person who completed cause of death	Item 23a) (Type.	Print)		Ju	me 17, 20	U)
			The onorto Miking	, () / E = /		Penn Stre	eet Balt	imore, Ma	ryland 21201
	Sta	te	31. Date filed (Month, Day, Year) 2 2 2005 32. Projectar's S		1				
	Registr	ar	JOH & & 2003	S A	could .				

			1 - For State Registrar	State of Ma	aryland / De	partment of leartificate of	lealth and N Death	лental Hyg R	eg. N 2005	21220
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea	th Dav Year	3. Time of Death
	/Medic		Julius George			11 03 T		June 9,		7:45 P M
7	Examin	ıer	4a. Facility Name (If not institution, give s		ooko	Linthi	or Location of Death		4c. County of Death	
			Hospice House of t		e (In yrs. last birthda	y) If Under 1 Year		8. Date of Birth	9 Birtl	nplace (State or Foreign
	Funeral Director		578-16-9528	M 2□F 85	9	Months Days	Hours Min.	(Month, Day	, Year) Co	sylvania
	۳ ,		Usual Residence of Decedent		40- Oit- T	1				
	72 hours after death with the Maryland natural; or items 23s or 28s-f show ilical Extendration by Inditied at	'n	10a. State 10b. County Maryland Anne Aru	ndel	10c. City, Town or	polis				10d, Inside City Limits 1 ☐ Yes 2 X No
	the M	Funeral Director	10e. Street and Number			10f, Zip Code		1	0g. Citizen of What Co	untry?
	3a or	ā	2501 Eastern Point	Ct.		214	01		USA	<u>-</u> , .
	ms 2	nera		12. Was Decedent Armed Forces?	Ever in U.S. 1		Hispanic Origin? (Sp ean, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
9	or ita	Fu /	1 Never Married 2 Married	1X Yes 2 ☐ f	No	1 Yes 2X No		riicari, etc.)	Black, White	White
5-0036	urai',	d by	3 Widowed 4 Divorced	Year or Dates:	···					
	in 72	lete	15. Decedent's Edu (Specify only highest grade	e completed)	(Gi	cedent's Usual Occu ve kind of work done . DO NOT use retire	during most of work	king	16b. Kind of Business/	industry
2121	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5 4 years		way Desig	n Enginee	r	D.C. Gove	rnment
Pu	e file al Hyg I otha vent,	Be C	17. Father's Name (First, Middle, Last)		<u>.</u>		18. Mother's Nam			- · · · · · · · · · · · · · · · · · · ·
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural; or items 23a or 28e-f show or other traumatic event, the Medical Examination was be indiffied at	To	Frank White						yniarski	
Mar	12 sh h and 7 is m raum		19a. Informant's Name/Relationship (Ty	,	6204	take persent			r, City or Town, State, 2	
e,	1 and Healt em 2		Dorothy I. White/ 20a. Method of Disposition	Wife	20b. Place of Dis	position (Name of		Date Annar	colis, MD 2 20c. Location - City or	1401 Town, State
nor	ant of it: If it y or o		Washington 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		rematory or other pla rans Ceme		-05	Crownsville	e. MD
Baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Survice License	90					Kalas Fune	
ä	Depariment of the part of the		What I the						ldgewater, 1	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each fi	the death. Do not one.	enter the mode of dy	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Meta	static	pancrea	tic Ca	ncer		Chisot and Boam
	/Medical Examiner		resulting in deality	Due to (or as	a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	outed id ansit	Examiner	that initiated events							
0,	e exectian an urial-tr		resulting in death) Last	Due to (or as	a consequence of):					
8760,	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical		1.					1	
9 X	ding p	/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date of deli	VAD/
Вох	death e atten ed for u	ciar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death	B □Ectopic pregnand □ Other (specify) _	y		Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unknown						
	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions cor	ntributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.		bacco use contribute to	
ord	v requir been s should	ted						1 🗆 Y		obably 4 Unknown
ě	as b	Completed						24a. Was a autops perform	sy prior to d	topsy findings available completion of cause of
al F	The ate							1 ☐ Yes	2 No 1 Yes	2 No
V.	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	ent 2 ER/Outpat	ient 3 DOA	han	th (Check only or	ence 6 X Other (Spec	Hospice
of		n: To	27. Manner of Death	28a. Date of Inju	iry 28b. Time	of 28c. Inju			ow injury occurred	House
ion	Attending F r death. actor: After i by the funera	atio	1 Natural 5 Pending 2 Accident investigation	(WORL), Da	y 1 bai) Illijul		Yes 2 □ No			
Division of Vital Records,	or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	pital o		29a. Certifier 1 Certifying Phys	nining. To the host	of my knowledge, de	ath accurred at the t	imo, data and place	and due to the c	ause(s) and manner as	etated
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical			f examination and/or				ate and place, and due	
	within To th comp	Me	29b. Signature and title of certifier			29c. Licen		2	9d. Date signed (Month	n, Day, Year)
			Keeth Wan	sher "	's	05	7019	٠,	June 10,	2005
			30. Name and address of person who con Keith Damsker,				Land Rd. A	nnapolis	s, MD 21401	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2005 JUNE 1740 P ^M CELESTINE TERESA BARNETT WATERS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, JUNE 2, 5. Social Security Number 6. Sex 9. Birthplece (State or Foreign **Funeral** Months Days Hours 1945 1 □ M 2 🙀 F MARYLAND Yrs. 217-46-7196 60 Director Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or items 23e or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** BRYANS ROAD MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2560 MARSHALL HALL ROAD / P.O. BOX 1153 20616 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Itel any injury or other freumatic event, the Medical Examir net 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT 12TH GRADE (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT DC PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SYDNEY BARNETT FRANCES BROOKS BARNETT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1153 BRYANS ROAD, MARYLAND 20616 GERALD W. WATERS / HUSBAND 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEMETERY JUNE 15, 2005 CHELTENHAM, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) LIDIA C. THORNION JOHNSON MO0583 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ne /Medical as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown for Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown þ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No Division of Vital 1 Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 10 1 🗌 Yes 27 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) ā her of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After Injury Natural 5 Pending death. 1 Tes 2 No Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à hours after 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 To the F 29c. License number 29d. Date signed (Mogth, Day, Year) 29b. Signature and title of certifier 0303/8 and addre's of person who completed cause of death (Item 23a) (Type, Print) 30. Nam 3 JAMES CATEVENIS, MD 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 31. Date filed (Month, Day, Year) State Registra JUN 13 2005

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 Is marked other than "neture!", or items 23a or 28e-1 show eny injury or other traumatic event, the Medical Evandant must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physicien: The law requires that the death certificate be execused within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		for State Registrar	State of I	Maryland .	-	artment of h				giene Reg. No. 2 (005	21222
sicia	an	1. Decedent's Name (First, Middle	-						2. Date of Dea	ıth		3. Time of Death
edic	al			trick		4h Oh Tour		-4 D4	June	12	2005	10:10 a M
min	er	4a. Facility Name (If not institution Quail Run Ass:	•	•		4b. City, Town, o		or Death			ty of Death rford	
ral tor		5. Social Security Number 218–28–7120		Age (In yrs. last 72	birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birth (Month, Day 09/17/	1	9. Birth	place (State or Foreign intry) Jersey
		Usual Residence of Decedent 10a. State 10b. County		10c. City, T								104 1074 07 117
	ō	,	ford	roc. city, 1		erdeen						10d. Inside City Limits 1X Yes 2 □ No
	Director	10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Cou	intry?
	rai D	46 Smith Avenue	Э			2100	1			USA	A	
	Funerai	11. Marital Status	12. Was Decede Armed Force	s?	13. \	Was Decedent of H f Yes, specify Cub	lispanic O an, Mexica	rigin? (Spe an, Puerto f	cify Yes or No- Rican, etc.)	14. Ra BI	ace - Ameri ack, White,	ican Indian, , etc.
	by	Never Married 2 Married 3 Widowed 4 Divorced				1⊡ Yes 2∭∑ No	Specify	y:		Spec	ity: Wh	ite
	Completed	15. Deceden (Specify only higher	t's Education st grade completed)	1	(Give	dent's Usual Occup	during mo	st of workin	ng	16b. Kind of	Business/Ir	ndustry
	mpi	Elementary/Secondary (0-12)	College (1-40	or 5+)	life. I	00 NOT use retire ephone 0	d)			Teler	ohone	
	Be Co	17. Father's Name (First, Middle,	Last)	1		cprioric o	-		(First, Middle,	Maiden Suma	ıme)	
	ToB	Charles Julius	Zentrick				He]	len Vi	rginia	Sunda	ay	
		19a. Informant's Name/Relations		1		ag Address (Street Carol Av					n, State, Zij	p Code)
	- 19	LaRue Jacobs (f	rrend)	20b. Place	of Dispo	sition (Name of	1		ate	20c. Location	- City or T	own, State
.		¹XDBurial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		IA I		natory or other pla etery	, I	6/15/	2005	Aberdee	en, Ma	aryland
once.		21. Signature of Funeral Service	Licensee	1/2	Ta	rring-ca erdeen,	isset Fair I go I Marvel	unera	1 Home	, P.A.		
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	sed the death. I								Approximate Interval Between
an i		Immediate Cause (Final disease or condition	AAU	nucock	Pa	rkinse	2 4	Ass	Pane	2		Onset and Death
al er		resulting in death)	Due to (or	as a consequen	ce of):	1121.		()	10,000			
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or:	as a consequen	ce of):	a we	nev	-0-1	er ve	NOU		
d	Exan iner	that initiated events	S c									
	EX	resulting in death) Last	Due to (or a	as a consequen	ce of):							
-	edical		d									
	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Fetal de		A Ectopic pregnance				23d. D	ate of deliv	ery
	sicia	in the past 12 months? 1 Yes 2 No		at time of death		Other (specify)				N	lonth	Day Year
	Phy	9 ☐ Unknown Part II. Other significant condition	ons contributing to death	but not resultin	a in the ur	nderlving cause giv	en in Part	I.	23e. Did to	bacco use co	ntribute to t	the cause of death?
	d by	OHTH @) PVD 3	MOR	Na	St Ca	-		1 🗆 Y		_	bably 4 Unknown
	piete								24a. Was a		. Were auto	opsy findings available ompletion of cause of
	Completed by Physician/Me								autop: perfor 1 Yes	med? 2 D No	death?	2 No
	Be	25. Was case referred to medical examiner?	Hospital:			Oth	ac		(Check only or			Assisted
	n; To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of In	njury 28	Outpatien b. Time of	28c. Injur	y at		ne 5 Residente 16		ther (Specif irred	Living
	atio	1 Accident 5 Pendin investig	gation	Day Year)	Injury	M 1	γγ Yes 2 [No				
.]	ertific	3 Suicide 6 Could ideterm	ined 286. Place of	Injury - At home etc. (Specify)	, farm, str	eet, factory, office		2	8f. Location (S City or Town	treet and Num n, State)	ber or Rura	al Route Number,
	aj Ce	29a. Certifier 1 Certifyin	ng Physician: To the be	st of my knowled	dge, death	occurred at the tir	ne, date a	nd place, a	nd due to the c	ause(s) and m	nanner as s	stated.
	Medical Certification: T	one)	Examiner: On the basis and manner	of examination	and/or inv	estigation, in my o	pinion, de	ath occurre	d at the time, d	ate and place	, and due to	o the cause(s)
	2	29b. Signature and title of certifie	Alenn	Ab.		29c. Licens	e number	21	2	9d. Date sign	ed (Month,	Day, Year)
		30. Name and address of person	who completed cause o	f death (Item 23	(1)	Print) 1. Rd	Ste	# 20	oo Bo	et	10	21237
Sta istr		31. Date filed (Month, Day, Year)	32. Re	strar's Signature)	bart.						
点 核				2771		AND DESCRIPTION OF THE PERSON						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

			1 - State Amend Ite	m 10g	State o &Unpe r	f Mai nd I	ryland/Dep tem 23a&2	artment of F <i>tificate^{mo}f</i>	lealth and 6%5 h 7 -2	Mental Hy 21-05 tas	giene	00-	
			Decedent's Name (First, M.							2. Date of De		005	3. Time of Least
	Physici /Medic		Darlene Vera	Arm	stead	i				JUNE	20,	2005 ^{Year}	1630 PM
	Examin		4a. Facility Name (If not instit	-				4b. City, Town, o		ath	4c. (County of Deat	h
_			MARYLAND GENI		OSPITA			BALTIMO		ro o D + -//D:		0.00	
200	Funeral Director		5. Social Security Number 216-94-4261		M 2 XF	7. Age	(In yrs. last birthday) 36 Yrs.	Months Days	If Under 24 Hi Hours Min		ay, Year)	9. Birti Co ML	hplace (State or Foreign untry))
3	land ow		Usual Residence of Decedent 10a. State 10b. Co.				10c. City, Town or L	ocation					10d. Inside City Limits
	with the Marylan s or 28a-1 show be notified at	tor	MD				Balti	more					X Yes 2 No
	h the	lrec	10e. Street and Number					10f. Zip Code			10g. Citiz	en of What Co	untry?
	th with	a D	1437 Argyle	Ave.				2121	7		UA:	s us	A
920	tiled within 72 hours after death with the Maryland Hygiene. sther than "natural", or Itams 23a or 28a-1 show ent, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status Sepa. 1 Never Married 2 3 Widowed 4 Divo	Married	2. Was Dec Armed Fo 1 Tyes If Yes, Gir Year or D	2 No ve	ver in U.S. 13.	Was Decedent of HII Yes, specify Cub.	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Netro Rican, etc.)		4. Race - Ame Black, White Specify: B1	ncan Indian, e, etc.
5-0	72 hours "natural", idical Exa	Completed	15. Dece (Specify only h	dent's Educ ghest grade	ation completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most of w	rorking	16b. Kin	d of Business/	Industry
121	s 1 and 2 should be filed within 72 h Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medical	Jumo	Elementary/Secondary (0-10th	2)	College (1-4or 5+	Sal		3)		Clot	thing	
9	should be filed with nd Mental Hygiene. : markad other thai .matic event, Ine.	Be Co	17. Father's Name (First, Mid	dle, Last)			Jul		18. Mother's N	ame (First, Middle			
lan	uld be Aenta rkad tic ev	To B	Charles Dou	glas					Doris	Armstea	ad		
ary	i 2 should be filed v n and Mental Hygie i is markad other t raumatic event, III		19a. Informant's Name/Relat	onship (Typ	e, Print)		19b. Mail	ng Address (Street	and Number or I	Rural Route Numb	er, City or	Town, State, 2	Zip Code)
Σ,	and and and and and and and and and and		Doris Armste	ead (mothe	er)		xford Co			212		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2.2 Department of Health at Important: If item 27 Is any injury or other trau 2008.		20a. Method of Disposition 1		moval from	State	20b. Place of Disponentery, cre			Date		cation - City or	
量	nit. Partme artme ortsnt injury		' 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Sen		0/	7	Sacred 1	Heart 2. Name and Addre	ss of Facility Ta	28-05	Dund	dalk,	MD
B	permit. Departr Imports any inji		Meald		Hun		2	007 East	ern Av	e. Balt	to. N		
			23a. Pert1. Enter the disease shock, or heart failure	, or complic List only one	ations that of	caused t	he death. Do not en	ter the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Physician	6 4	Immediate Cause (Final disease or condition resulting in death)	a.			isorder						Onset and Death
	/Medical Examiner		,		Due to	(or as a	consequence of):						
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1 .	Due to	(or as a	consequence of):						
	ificate be executed g physician and as the burial-transli	Examiner	that initiated events resulting in death) Last	c.	Due to	(or as a	consequence of):						
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687	g physi as the b	edical		0.									
.O. Box	Hospitel or Attending Physicien: The law requires that the death cert 24 hours after death. Funeral Director: After this certificate has been signed by the attendintely filled in by the funeral director, page 2 should be detached for use:	by Physiclan/M	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23	1 Live	oirth 2 nant at ti		□Ectopic pregnance □ Other (specify) _	<i>'</i>		2:	3d. Date of deli Month	ivery Day Year
0	es that igned b	by Pi	Part II. Other significant cor	ditions cont	ributing to d	eath but	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco us		the cause of death?
ord	w require been sig should b				· · · · · · · · · · · · · · · · · · ·					1 🗆	Yes 2	¶No 3∏Pr	obably 4 Unknown
Division of Vital Records,	: The law r cate has be page 2 sh	Completed								24a. Was auto perf		24b. Were au prior to death? 1 Yes	topsy findings available completion of cause of
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to me examiner?	<u> </u>	ospital:			at 3X DOA Ott	or	eath (Check only			
of	Phys this ral dir	5. T	1 XYes 2 No 27. Manner of Death	1	. 1		t 2 ER/Outpatie	IL SEX DOA	4 Li Mursing	Home 5 ☐ Res 28d. Describe			city)
o	ding h. After funer	tlon	1 X Natural 5 □ Pe	nding estigation	28a. Date (Mon	th, Day	Year) Injury	Wo	k? Yes 2 □ No	200. 50001150	non injury	00001100	
ivisi	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Place build	of Injur	y - At home, farm, si (Specily)			28f. Location City or To	(Street and wn, State)	Number or Ru	ıral Route Number,
Ω	pitel o		29a, Certifier 1 ☐ Cert	fying Phys	icient To the	host of	my knowledge, dea	h conversed at the ti	mo, date and pla	on and due to the	021150(5)	and manner as	stated
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical				asis of e	my knowledge, dea examination and/or in ed.						
	To the within 2 To the comple	M	29b. Signature and title of ce	tifier	/	11	4	29c. Licens			29d. Date	signed (Monti	
			20 Norman and 1	104		N Contract	ath (Itam 22a) /Time				JUNI	E 21,	2005
_			30. Name and address of pe	H66	TAT	$\overline{}$			n Street	t Baltir	more,	Maryla	nd 21201
	Sta Regist		31. Date filed (Month, Day,) JUN 2		32	Registra	's Signature	sife.					

Elem & Sparke

DHMH 17 Rev 1/2001

as Donald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 2. Date of Death Decedent's Name (First, Middle, Last, JR. Month 6 Day Year **Physician** Robert BROWN 20 12:11 AM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7. Age (In yrs. 9. Birthplace (State or Foreign st hinthday **Funeral** 213 60 5420 1**X**M 2□F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County City, Town or Location 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. and it items 23£ or 28a-f ahow ant: If item 27 is marked other than "neturel", or Items 23£ or 28a-f ahow ury or other traumatic avent, Item Modical Examine must be notified at 1 Yes 2 □ No Completed by Funeral Director h McOu 10g. Citizen of What Country? Street and Nur Was Decedent Ever in U.S. Armed Forces? 1 December 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race American Indian Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Father's Name (First, Middle, Last) nleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 Department of Health a Important: If itam 27 is any injury or other tra nod of Disposition Ob. Place of Dispos Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sur shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR Physician /Medical Due to (or as a consequence of): **Examiner** CARIORESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HYPERTENSION burial-transil Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE: esu. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ OVERWEIGHT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an certificate has autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KER/Outpatient 3 DOA 2 1 Yes 2 🗌 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of a Hospital or Attending P 24 hours after death. 5 Funarel Diractor: After t Certification: 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide To the Hospital within 24 hours a To the Funerel C 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16306 23 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

CHOMYALIT, M.D.

JUN 2 8 2005

BELAIR

			A Company of the Comp	partment of Health and Mertificate of Death	Mental Hygiene	21226
	Physic /Medi		1. Decedent's Name (First, Middle, Last) MARCUS BUSB	√	2. Date of Death Month Day Yes	3. Time of Death
1	Examir		4a. Facility Name (If not institution, give street and number) BON SECOUR HOSPITAL	4b. City, Town, or Location of Death FOUNW - BALTIMINE	STREET BALTIN	eath MRE MD 200
	Funeral Director		5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthda 7 Yrs. Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) M.	Birthplace (State or Foreign ARYLAND
	e Maryland 8e-f show	ctor	10a. State 10b. County 10c. City, Town or BALT	Location IMORE		10d. Inside City Limits 1√ Yes 2 □ No
	th with the 23a or 23 ist be no	ai Dire	2206 W. LANVALE STREET	10f. Zip Code 21216	10g. Citizen of What U.S. OI	,
5-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mantal Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-f show or other freumatic event, the Marical Examination unstable multiple of the recommendation.	Completed by Funeral Director	3 Widowed 4 Divorced Year or Dates:	B. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto		merican Indian,
21215-	d within 72 giene.	ompiete	(Specify only highest grade completed) (Gillier Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) BORER	ing 16b. Kind of Busine	,
Maryland	should be filed ind Mental Hygid s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) CLARENCE O. BUSBY	FLORENC	e (First, Middle, Maiden Sumame) CE WHITE	
	Tand 2 sho Health and tem 27 is ma		FLORENCE BUSBY (MOTHER) 220 6	iling Address (Street and Number or Rura W. LANVALE STR position (Name of	EET BALTIMORE	,MD. 21216
Baltimore,	t. Partmer		Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify)	ON CEMETERY 3/18	/05 LANSDOWNE	, MARYLAND
Ř	Depar Impor any ir			22. Name and Address of Facility LEWIS T. GWYNN 517 PARK HEIGHT	FUNERAL HOME 2 S AVENUE BALT	1215-6393 O MD Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	nter the mode or dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	H SHOCK		400028
8760,	cate be executed ohysician and the burial-transit	i Examiner	resulting in death) Last Due to (or as a consequence of):	RAJOLY FAILU	n€	PDAYS
9	rtificate I ng physi as the b	Aedicai		PNEU MON/A		ZYAV
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of c Month	delivery Day Year
	 requires that been signed t should be det 	by		underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3	to the cause of death? Probably 4 □Unknown
Vital Records,		Completed	M. I	or now n	24a. Was an autopsy prior to death	
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death		
ion of	fler inel	-	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	THE SEL DOX 4 INDISING HOR	ne 5 Residence 6 Other (Sp. 28d. Describe how injury occurred	pecify)
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street and Number or I City or Town, State)	
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause(s) and manner and at the time, date and place, and di	as stated. ue to the cause(s)
	To t	Σ	29b. Signature and title of certifier May bely, Mo	29c. License number	29d. Date signed (Moi	nth, Day, Year)
	0		30, Name and address of person who completed cause of death (Item 23a) (Type JANE) V - MOCHMEN, MD	Print) FOR W. BAL BANIMORE	TIMURE STRE	ET
5.	Sta Registr		31. Date filed (Month, Day, Year) 2. Registrar's Signature	who is	0 119 57	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Year Physician JUNE HANNAH BRAXTON MILDRED 26, 6:30 2005 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE 1813 MORELAND STREET

5. Social Security number

6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2□F 94 Vrs Director 216 32 617 Usuel Residence of Decedent 6170A OCT.12,1910 North Caroli Pagas 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural; or hems 23s or 28s-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or thems 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at X□Yes 2□No N/O MD. BALTIMORE Director 10e Street end Number 10f. Zio Code 10g. Citizen of What Country? Funeral 1813 MORELAND 21216 AVENUE U.S. ofΑ. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Dates: 1 Never Married 2 Married Specify: AFRICIAN 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced AMERICAN Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS 6тн UNKNOWN CUSTODIAN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ CLARENCE ROUNDTREE NICY CARR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If Item 27 is any injury or other trau CHRISTINE RUCKS (DAUGHTER) 1813 MORELAND AVENUE BALTIMORE, MD. 21216 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) PK.6/30/05 LAUREL MD. P.G. Co. MARYLÁND NAT. MEM. 21. Signature ... Funeral Service Licenses 22. Name and Address of Facility LEWIS LEWIS T. GWYNN FUNERAL HOME 21215-6393 T. GWYNN Pem—inter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. BALTO, MD Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 0 Examiner Due to (or es e consequent e of Examiner or Attending Physician: The law requires that the death certificate be executed bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, attanding physician for use as tha bunal Be Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No within 24 hours aftar death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigetion 1 Tyes 2 □ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 0059014 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Wa

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 8 2005

2. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2:15 AM Louis Donald Burgy June /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3701 Cattail Greens Court Glenwood Howard 8. Date of Birth (Month, Day, Year) June 22, 1925 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New Jersey **Funeral** Days 1 M 2 □ F 80 147-14-9523 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Glenwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 Cattail Greens Court 21738 **USA** Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If tem 27 la marked othar than "natural", or ham any injury or other trainment. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ETATE APPRAISE Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Burgy Rose Koenig ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3701 Cattail Greens Court Glenwood, Maryland 21738 Judith B. White, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 6/27/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Doensee 22. Name and Address of Facility
Cremation Society Of Maryland Inc. Thomas Du Thomas Gre or 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CHROME REMAN FOURKE Examiner Examiner certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ng physician a P.O. Box 68760. Physiclan/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 2 Yes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation To the Hospital or Attanding within 24 hours after death.

To the Funaral Director: Afte completely filled in by the fur 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) SAUCS N. MM 5540 TENOACS RS CHAPLES VILLE.

32. Pagistrar's Signature

Beautiful

Bouli 31. Date filed (Month, Day, Year) JUN 2 8 2005 Registrar

		1 - For State Registrar	State of Ma	-	epartment of F Certificate of		, 0	ene 9. 12. 0. 0. 5	21220
Physicia /Medic		Decedent's Name (First, Middle, JOHN	Last)		BORIS		2. Date of Death Month		3. Time of Death
Examin		4a. Facility Name (If not institution, of Bellimore Rocks)			15	or Location of Death	re	4c. County of Deat	h
Funeral Director		5. Social Security Number 200-05-9729 Usual Residence of Decedent	Sex. 7. Ago #⊞M 2□F 8	6 (In yrs. last birtho	Months Days	ff Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January	^{9. Birt} 26, 1919	hplace (State or Foreigi untry) Pennsylvani
e Maryland ie-f show	ctor	10a. State 10b. County Maryland Baltime	ore	10c. City, Town of Catonsv:					10d. Inside City Limits 1 ☐ Yes 2 No
ath with th	rai Director	10e. Street and Number 6001 Burnt Oak			10f. Zip Code 21228		U	g. Citizen of What Co Inited Sta	•
72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Jigal Examinational be routified at	l by Funerai	11. Maritaf Status 1 □ Never Married 2 □ Married 3 ○ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? IMATE Yes 2 N If Yes, Give Year or Dates:	Everin U.S.	13. Was Decedent of H ff Yes, specify Cuba 1 ☐ Yes ※XNo		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh:	e, etc.
within ene. then *	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5 4 year	+)	ecedent's Usual Occup live kind of work done fe. DO NOT use retired CTV1SOT	during most of work		6b. Kind of Business/ Inited State Postal Serv	
be file Ital Hy od oth	To Be C	17. Father's Name (First, Middle, La Mitro Boris				18. Mother's Name	e (First, Middle, M. a Oblous		
		19a. Informant's Name/Relationship Sandy Raitzyk	(Type, Print)	4324	ailing Address (Street Mary Ridg	ge Dr.Rand			
permit. Pages 1 and 2 should Department of Health and Mere Importent: If Item 27 is marks any injury or other treumatic <u>once.</u>	,	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	Removal from State cify) Mary	land Vete	isposition (Name of crematory or other place erans Cemet 22. Name and Addre 8728 Liber	ery June	27, 2005 ing Byers	Funeral I	lls, MD Directors,I
/Medical Examiner but yakicien and burial-transit	dicai Examiner	23a. Pary Enter the disease, or constitute, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listers of the first of the	a	a consequence of):		ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
death certif e attending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delined Month	very Day Year
law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death bu	it not resulting in th	e underlying cause giv	en in Part I.		cco use contribute to	the cause of death?
The ate h page	e Completed	PVD 25. Was case referred to medical					24a. Was an autopsy performe	prior to o death?	opsy findings available ompfetion of cause of
ng Phys fter this ineral dii	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat		y 28b. Tim	ry Worl	at at		ce 6 □Other (Spec	ify)
el or Ati s after d l Direct d in by i		3 Suicide 6 Could not determine 29a. Certifier 1 Lertifying	building, etc	. (Specify)	street, factory, office		City or Town,	ŕ	
pit Sura fille	602	(Check only 2 Medical Fx.	Physician: To the best of aminer: On the basis of and manner sta	examination and/o	eam occurred at the tim r investigation, in my of	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as and place, and due	stated.
To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medicai	one) 29b. Signature and title of certifier			29c. License			I. Date signed (Month,	Day, Year)
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medic	0.107	mp.	ath /Itam 20c) T				Date signed (Month) SHIP MD 2 /	Day, Year)

	1 - State Registrar Ce		2005 2123
Physician /Medical Examiner	4a. Facility Name (If not institution, give street and number)	June 25	Year 2005 3. Time of Dear 2:00 p
Funeral	Fairhaven Health Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Sykesville If Under 1 Year If Under 24 Hrs. 8, Date of Birth	Carroll
Hygiene, the matural, or items 23a or 28a-1 show of the the medical Evand varioust be notified at completed by Funeral Director	150-12-4574 1 1 2 F 79 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		r) (Country)
or Items 23a or 28a-1 st of arrithmst be notified Funeral Director	Md Carroll Sykesvill 10e. Street and Number 7200 Third Ave. C-152	10f. Zip Code 10g. C	1 ∰ Yes 2 ☐
ital hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Evant art must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 7 8 2 No WWII 1986, Give WWII 1986, Give 1986 or Dates:	USA Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
ygieneer than "natural", o .t, the Medical Evan Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) +4 Manage	DO NOT use retired)	Kind of Business/Industry
	17. Father's Name (First, Middle, Last) James P. Van Blarcom Sr.	18. Mother's Name (First, Middle, Maide Alice Ainlay	n Sumame)
of Health and Meritem 27 is marker other traumatic	Gloria Van Blarcom (spouse) 7200	ng Address (Street and Number or Rural Route Number, City Third Ave., C-152, Sykesvil	le, Md 21784
rtment o rtent: If njury or	1 Durial 2 Dicremation 3 Removal from State 1 Donation 5 Other (Specify) **A Donation 5 Other (Specify)	ratory or other place) Ty Cremation 6-28-05 Syk	esville, Md
Depa Impo any ii	Pary daight derbert 23a. Part. Enter the disease, or complications that caused the death. Do not entered to the part follows.	R. Name and Address of Facility Haight Funera P.O. Box 195 Sykesville, Md	1 Home & Chapel 21784
physician and maintenant sthe burial-transit aurignment street Examiner	d	Dementi	Interval Betwee Onset and Deat
ed by the attending process detached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
be o	Tark in Street anguincant contained a contributing to death but not resulting in the un	iderlying cause given in Part I. 23e. Did tobacco	use contribute to the cause of death
2 S		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause death? 1 ☐ Yes 2 ☐ No
tor: After this the funeral dication: To	25. Was case referred to medical examiner? 1	28c. Injury at Work? M 1 Yes 2 No	
within 24 hours after of to the Funeral Direct completely filled in by Medical Certifications.	29a. Certifier 1 Certifying Physicien: To the best of my knowledge death	City or Town, State	9)
To the Funeral Completely filled completely filled	29b. Signature and title of certifier	29c. License number 29d. Da	te signed (Month, Day, Year)
6	30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) ALL Ca-for Distract Res	Peinfonton, M.

			For State Registrer		State of I	Maryland		artment rtificate				ental Hy		00	5	21	23	
				e (First, Middle, Last)							2. Date of De	eath			3. 1	ime of De	ath
	Physici /Medic			Marjor	ie Beau	dry Bea	attie					Month June	23, Day	2005	Year	8	:15	РМ
	Examin		4a. Facility Name (/	f not institution, give	street and numb	өг)		4b. City,	Town, or	Location of	of Death		4c.	County o	f Death			
		•		ry Hospic						ville				Mont				
В	Funeral Director		5. Social Security N 579-20-2	2421	х]м 212]F	Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D. July	rth ay, Ye <i>ar)</i> 2, 1		Cou	ntry)	State or F nuset	
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Le	ocation							T	10d. In:	side City I	imits
	Maryi f sho	Ιō	Maryland	Montgome	rv	Be	ethesd	a]Yes 2]	
	r 28e	rec	10e. Street and Nur		- 7			10f. Zip	Code				10g. Cit	izen of WI	nat Cou	ntry?		
	h with	a D	5928 Kirb	y Road				20	817				Uni	ted S	Stat	es		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show any injury or other treumatic event. Ite Modical Examiliar is usable multiple at once.	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 🛣 Widowed	ied 2 Married 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ∑No		Was Deced If Yes, spec	ify Cuba	ispanic Ori in, Mexican Specify:	gin? (Spe n, Puerto i	cify Yes or N Rican, etc.)	0-	14. Race Black Specify:	, White,	etc.	lian,	
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	iled v lygie ther t		17. Father's Name	(First Middle Last)	5+		DIEC	ICIAII	-	19 Motho	r's Nama	(First, Middle	Maidan	Cumama	1			
Maryland	d be f antal h ed of	To Be	Louis Be									Lothr)			
Z	shoul nd Me mark	Ĕ		ame/Relationship (T	ype, Print)		19b. Maili	ng Address	(Street			l Route Numb			tate. Ziu	o Code)	
M	nd 2 atth at 27 is 27 is ir treu		Lenore B	Beattie Cl	ark/Daug	ghter						nsingt						
Baltimore,	Pages 1 a ent of Hea nt: If item ry or othe	8		position Cremation 3 F		ate Mon	lace of Dispo emetery, cre tgome1	osition (Nam matory or of Cy Cre	ne of ther place mate	orium	June 200			hesda				
Balti	permit. I Departm Importer any injur			uneral Service Licens		Inc.	2	2. Name and thesd	d Addres	ss of Facili nevy (larv1a	Rohe	rt A. Inc. 0814-3	Pumpl 755	hrey 7 Wi	Fun	era ısir	l Hor Ave	ne nue
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P.O. Box 6	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 24 9 ☐ Unknown	months?		n 2 🗌 Fetal It at time of de	death 3[⊒Ectopic pro ⊒ Other (<i>sp</i> e						23d. Date Mont		ery Day	Yea	ır
	signed by	by	Part II. Other signif	ficant conditions co	ntributing to deat	h but not resu	ılting in the u	inderlying ca	ause giv	en in Part I.				use contrib			se of deal	
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Vital	ificati or, pa		25. Was case refer	rred to medical			-			26 Place	of Dooth	perf 1 Yes		1[Yes	2 🗆 N	lo 	
>	Physicien: this certificated director, I	To Be	examiner? 1 ☐ Yes 2 🏋	-	Hospital:	atient 2 🗆 1	ER/Outpatie	nt 3 DO	A Oth			ne 5 Res		6 17 Other	(Specif	ω Hc	spic	e
J Of			27. Manner of Deat	th	28a. Date of I		28b. Time o		8c. Injun	/ at		28d. Describe				,,		
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Division	tel or Atter s after de al Di ecto	Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place of	Injury - At ho , etc. (Specify	me, farm, st	reet, factory	, office		2	28f. Location City or To			or Rura	I Route	e Number	:
	To the Hospitel or Attending within 24 hours atterdeath To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)	1X Certifying Phy 2☐ Medical Exam	rsician: To the be iner: On the basi and manner	is of examinat	wledge, deal ion and/or in	th occurred and oc	at the tin in my o	ne, date an pinion, dea	d place, a	ind due to the ed at the time.	cause(s) , date and	and man	ner as s	tated. o the ca	ause(s)	
	To the within To the comp	ž	296. Signature and	I title offcertifier				29c	. Licens	e number			29d. Dat	te signed	(Month,	Day, Y	'ear)	
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DH	IMH 17 Rev 1/2	001						-/										

		-	For State Registrar	State of M	laryland		artment rtificate			and M	lental F		ne 20(05	212	232
			Decedent's Name (First, Middle, I	.ast)							2. Date of Month	Death			3. Time	of Death
	Physici: /Medic		Hannah Banas								June		Day 2005	Year	9:2	5 P. M
	Examin		4a. Facility Name (If not institution, g	ive street and number	r)		4b. City,	Town, or	Location o	f Death			4c. County	y of Death		
			Montgomery Gener				01n						Montg	,		
	Funeral			. Sex 7. A 1 □ M 2 □ X F	ige (In yrs. las	it birthday) Yrs.	If Under Months		Hours	Min.	8. Date of (Month,	Day, Ye	ar)	Cour	ntry)	e or Foreign
	Director		082-26-8708 Usual Residence of Decedent		75	113.					Nov.	25,	1929_	lre	land	
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation							1	10d. Inside	City Limits
	Man	to	Maryland Montgor	nerv	Rock	cville	p.								1 □ Y	es 2X No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g.	Citizen of	What Cou	ntry?	
	th will	aiD	5705 Luxemburg P	lace Apt.	#400		208	52_				Uni	ted S	State	s	
	r dea	Funerai	11. Marital Status	12. Was Deceder Armed Forces	s?	13.	Was Deced	lent of Hi	spanic Ori n, Mexican	gin? (Spi i, Puerto	ecify Yes or Rican, etc.)	No-		ce - Americk, White,		
36	hours after death with the Maryland tural', or Items 23s or 28e-f ehow al Examinational by notified at	ру Fu	1 Never Married 2 Married	If Yes, Give	_		1 ☐ Yes 2		Specify:				Specia	⁵⁄∵Whit	te	
8	s within 72 hours after death with the Marylan tiene. rithen "natural", or Items 23a or 28e-f ehow the Medical Examinat must be indiffed at	q pa	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's	Year or Dates		16a Dece	dent's Usua	I Occupa	ation			168	o. Kind of B			
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212	filed within Hygiene. other then "	mo	Elementary/Secondary (0-12)	College (1-40	r 5+)	Asse	mbler						Manu			
Maryland 21215-0036	nd 2 should be filed ith and Mental Hygis 27 le marked other rireumatic event, it	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	e (First, Mid	dle, Mai				
<u>la</u>	should be tind Mental I	To E	Martin Griffin						Brig	it W	lelsh					
a	and I and I e me		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rur	al Route Nu	mber, C	ity or Town	, State, Zip	Code)	
	s 1 and 2 f Health item 27 I		Maureen Ann Bana	s/ Daughte					lace A		400, R					
ore	ges 1 al t of Hea ff item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from Star	сеп	n <i>etery</i> , c <i>rei</i>	natory or o	ther place	· J	une	25 ,		c. Location	,		
ţį	tmen tent: tent:		`4 □Donation 5 □ Other (Spe	4	St. N	lary'	s Cem	eter	У	2005		De	witt,	New	York	II a m a /
Baltimore,	permit. Pages: Department of H Importent: If ite any Injury or of		21. Signature of June al Solvice Li	,	м01353						ert A West 2085			ry Av	enue	Home/
п			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause by one cause on each	ed the death. line.	Do not en	ter the mod	e of dying	g, such as	cardiac	or respirator	y arrest	,		Approxim Interval I Onset ar	Between
	Physician		Immediate Cause (Final disease or condition	_a Conges	tive He	eart 1	Failuı	re							Mont	
	/Medical Examiner		resulting in death)	Due to (or a	as a conseque	ince of):										
	Examine.	_	Sequentially list conditions,	b. Ischem	ic Care	diomy	<u>opath</u>	у							Mont	hs
	ped nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Corona			iaanaa	2							Vacan	_
	rate be executed only sician and the burial-transit	Examiner	that initiated events resulting in death) Last	V	as a conseque		LSeast	=							Year	S
8760,	siciar b buri			d												
89	ificate g phys as the	edic														
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregnand 2 Fetal d		⊒Ectopic pr	annancy					1	ate of deliv	,	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 🂢 No		at time of dea		Other (sp					-	М	onth	Day	Year
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ord	w requir been si should	ted	Staphlococcal Se						rtrla	a1_		Yes	2 No	3 10	Dably 4	∏Unknown
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H	10											s 2X		1 Yes	2 No	
Vital	tending Physicien: The leath. tor: After this certificate the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			17	Othe	0.00		h (Check or					
of	Phys this ral dir	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 🗆 Inpa		R/Outpatie 28b. Time o	nt 3🗓 DC	- A	4 14	irsing Ho	ome 5 P				fy)	
no	ding F h. After funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of I. (Month,	Day Year)	Injury	M	8c. Injun Worl 1 □	k? Yes 2□	No			, ,			
Division	Attending or death.	fica	3 Suicide 6 Could no	t be 28e. Place of	Injury - At hom	ne, farm, st	reet, factory	y, office			28f. Location			ber or Run	al Route N	lumber,
D N	after after Dire	Certification:	4 Homicide	building,	etc. (Specify)						City or	Town, S	State)			
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai C		Physician: To the be kaminer: On the basis	of examination											e(s)
	o the o the omple	Ne V	29b. Signatur) and title of certifier	7			290	c. License	e number				. Date sign			
	+ 3+ 0		1650 1 Co	and mi	,			D	287	91		J	inne	23.	200	5
1			30. Name and widdress of person w	to completed cause of the property of the prop	of death (Item :	- 11	./ "	nive	. 0	Ines	1 11)	7	uni 0832	- /		-
	· St	ate	31. Date filed (Month, Day, Year)		istrar's Signatu	·	1.11	····	1		11. 7			-		
	Regist		JUL	1282005	fee		do	alle!	p							

ORIGINAL

Physic	ion	 Decedent's Name (First, Middle, 	Last)			_		2.	Date of Dea Month	ith Day	Year	3. Time of Dec
/Med		Marvin	Henry		Carrol.				JUNE	24,		2:34
Exami	ner	4a. Facility Name (If not institution,			4b. City, To	own, or Lo	cation of	Death			County of De	
		Saint Joseph Med 5. Social Security Number 6		(In yrs. last birthda	Tows(Under 2	4 Hrs. o	Date of Birtl			e County
Funeral Director		214-58-7978	1 VM 2 I	52 Yrs.			lours		Month, Day	53 (1)	9. 6	irthplace (State or Fo Country) Md.
D >		Usual Residence of Decedent										
ath with the Marylan s 23a or 28e-f show	10	Md.	NA	10c. City, Town or I	Location altimor	e						10d. Inside City Li
the N 286-f	Director	10e. Street and Number	IVA		10f. Zip C					10a Citia	en of What C	
3a or	0	360 Shagbark Rd				1220				rog. Citizi	US	
death	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13	. Was Deceder If Yes, specify	nt of Hispa	nic Origi	in? (Specify	y Yes or No-	1.		erican Indian,
or ite	F	1 ☐ Never Married 2 ☐ Married			1 ☐ Yes 🄏		vexican, Specify:	Риепо ніс	an, etc.)	1	Black, Wh	
Jwithin 72 hours after des giene. r than "neture!", or items it a Modical Exurither m	d by	3 Widowed 4 □ Divorced	Year or Dates:								Specify:	Black
in 72	Completed	15. Decedent's (Specify only highest	grade completed)	(Giv	edent's Usual (re kind of work DO NOT use	done durir	ng most o			16b. Kind	d of Busines:	s/industry
l with	mo	12th grade	College (1-4or 5+)	3	. of He		And	miniza Chil	ation	Ci	ty of	Baltimore
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or items 23a or 28e-1 show eumatic event, the Modical Exertinger must be notified at	Be C	17. Father's Name (First, Middle, La	ist)			18.	. Mother	s Name (F	irst, Middle,	Maiden S	Sumame)	
should b ind Ments marked umatic e	To E	Henry		Carroll			E	Clizab	eth		E	rvin
es 1 and 2 should b of Health and Menta litem 27 is marked rother treumatic e		19a. Informant's Name/Relationship			ling Address (5							
1 and fealth im 27 ther tr	1	EaShella Stokle	ey Daught	20b. Place of Disp) Shagba		a.,					21220
Pages nent of h int: if ite		1 ☑ Burial 2 ☐ Cremation 3		cemetery, cr	ematory or other	er place)	1	Date				r Town, State
		' 4 Donation 5 Dother (Spe 21. Signature of Funeral Service Lice		Garrisc	n Fores	-	- 1	6–30–				lls, Md.
permit. Departr Importe any inju		De e		J	March		•		Baltin		Ma. North A	21202
7		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused th	ne death. Do not e	nter the mode of	of dvina. sı	uch as ca	ardiac or re				Approximate
Examiner	i i	resulting in death) Sequentially list conditions,	Due to (or as a o	consequence of:	eroscle	rotic	car	rdiova	scula	r di:	sease	Interval Between Onset and Deat
	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of the control of th		eroscle	rotic	car	rdiova	ascula	r dis	sease	Onset and Deat
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State

DHMH 17 Rev 1/200

State 31. Date filed (Moh) Day Year) 2005 Registrar

ZABIULLAH

2. Registrar's Signature

111 Penn Street

Baltimore, Maryland 21201

			For Stata Registrar	State o	of Maryland		artment of H rtificate of L		Mental Hygie	200	5 2	1235
ı	Physicia /Medic		1. Decedent's Name <i>(First, Middle</i> Eloise Carson), Last)					June 23,	^{Day} 2005	Year	3. Time of Death $12:45 \ \ P^{\text{M}}$
Ĭ.	Examin		4a. Facility Name (If not institution	i, give street and nu	ımber)		4b. City, Town, or	Location of Deat	h	4c. County	of Death	
		в	Mariner Health				Glen B			Anne A		
H	Funeral Director		5. Social Security Number 215-14-7659	6. Sex 1 □ M 2√ F	7. Age (In yrs. la 90		If Under 1 Year Months Days	Hours Min.		'ear) 914	9. Birthplace Country Ohio	ce (State or Foreign)
			Usual Residence of Decedent						рес 7, 1			
	arylan ahow	۱	10a. State 10b. County			Town or Lo					10d	. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-11	Director	110	Arundel	Cu	rtis 1	10f. Zip Code		100	, Citizen of W	hat Country	
	with ti	급	10e. Street and Number				21226		109			1
	leath ms 23	Funeral	3819 Pascal Ave	12. Was Dec	cedent Ever in U.S	6. 13.	Was Decedent of H	spanic Origin? (S	Specify Yes or No-		- American	
٥	after or iter		1 Never Married 2 Marr	ried Armed F	2 XNo	i	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	n, Mexican, Puer Specify:	to Hican, etc.)		k, White, etc	2.
50	urel',	d by	3 XWidowed 4 ☐ Divorced	If Yes, G Year or I	Dates:					Specify:	te	
7	"natu	lete	15. Deceden (Specify only highe			(Give	dent's Usual Occup: kind of work done o DO NOT use retired	turing most of wo		b. Kind of Bu	siness/indu:	stry
7.	tied within 72 hours after death with the Maryland Hygiane. other than "naturel", or Items 23e or 28e-f show ant, the Medical Eraniner must be notified at	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	Home	emaker	,		Own Hor	ne	
פ	e filec al Hyg othe vant,	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle, Ma	iden Sumam	e)	
<u>X</u>	2 should be f and Mental P I a marked of raumatic eva	To	Jacob Elmer A						Gilmore			
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiens. If item 27 is marked other than. If item 27 is marked other than "naturel", or items 23e or 28e-1 show or other traumatic event, the healted Eren iner must be notified at		19a. Informant's Name/Relations Mrs. Shirley We		aughter		•		ural Route Number, (Pasadena, I			ode)
<u>ნ</u>	permit. Pages 1 and 2 s Department of Health an Importent: If item 27 la any injury or other trau		20a. Method of Disposition				osition (Name of matory or other place			c. Location -		n, State
<u></u>	Pages ent of nt: If i		1 ☐Xurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		I State)	7/2005 G	len Bu	rnie,	MD
att	partm porte y inju		21, Signature of Francis	Ricensee		-			ngleton F			
<u>n</u>	8818		Micau	My 11	NO1319				Glen Bur			
تنفيا	Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on	DEME	NT		g, such as cardia	c or respiratory arres	t,	l Ir	oproximate nterval Between Onset and Death
e.	/Medical Examiner		resulting in death)	Due to	(or as a consequ	ence of):	MACCI	1 A-R	ACCIDE	NI		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	o (or as a consequ	ence of):	-V N3 C D					
V	cuted td ransit	Examiner	that initiated events	S . 1	ty DER	JEN	310N					
Ö,	sate be executed physician and the burial-transit	I Exa	resulting in death) Last	Due to	o (or as a consequ	ence of):						
8760,	cate b physic the b	dical		d		-						
× 6	death certificate be executed attending physician and of for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnar					23d. Date	e of delivery	
. Box	death e atter	iciar	in the past 12 months?	4☐Preg	birth 2 ☐ Fetal gnant at time of de		⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			Mor	nth D	ay Year
P.O.	that the de ed by the a detached t	hys	9 Unknown	9□ Unk					an Diduk		ili a la ala a	and a state of the
rds, I	w requires that the been signed by th should be detache	ed by	Part II, Other significant conditi	I		Iting in the u	Inderlying cause giv	en in Part I.				cause of death?
ဝ၁	aw ls b	Completed	OSTEOAR	THRIT!	S				24a. Was an autopsy	p	rior to comp	y findings available pletion of cause of
ř	The ate h page	Com							performe 1 Yes 2	ANo 1	leath?	K No
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			Oth	00	eath (Check only one)			
of	Phys this ral dii	2	1 Yes 2 No	28a. Dat	Inpatient 2 2 5 e of Injury	ER/Outpatie 28b. Time of	of 28c. Injur	y at	Home 5 ☐ Residen 28d. Describe how			
0	Attanding Phy ir death. actor: After thi by the funeral of	tlor	1 Natural 5 ☐ Pendii 2 ☐ Accident invest	ng (Mo igation	onth, Day Year)	Injury	M 1	k? Yes 2 □ No				
Division of Vital Records,	spitel or Attandii ours after death. naral Diractor: A filled in by the fu	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286, Flat	ce of Injury - At holding, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	er or Rural I	Route Number,
	2 C = >	edical C		Examiner: On the					e, and due to the cau curred at the time, dat			
	To tha Hos within 24 h To tha Fun completely	Me	29b. Signature and title of certific	3r			29c. Licens			d. Date signed		
),			> PC) L	ahur	m, w	v.>>.	D	1775	3	6.	24.1	05
	5		30. Name and address of person	who completed ca	use of death (Item	23a) (Type	710 CH	RCH J	T. BALT)	Mon	E, n	ND 21225
	St Regist	ate rar	30. Name and address of person K , S , D H 31. Date filed (Month, Day Year	8 2005 32.	Registrar's Signat	tude A	John J.					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** oladys (0/1/NS 2005 June 26 /Medical 5:25p 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Continuum Care At Sykesville Sykesville Carroll If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 93 vre **Funeral** Birthplace (State or Foreign Country) Days Hours 216-30-3180 1 □ M 2 1 F Months Director Jan 2 1912 Md Usual Residence of Decedent with the Meryland 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Md Carrol1 Sykesville Director 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5753 Bartholow Road 21784 USA Peges 1 and 2 should be filed within 72 hours efter deeth vent of Health and Mentel Hygiene.
Int: If Item 27 is marked other than "natural", or theme 23inty or other traumatic event, the Medical Examinar must Funeral 11. Marital Status Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Saltimore, Maryland 21215-0036 1□ Yes 2□ No Specify: Specify: black ģ 3 □ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) health care nursing assistant 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George W. Chase Eugenia Brodus 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Joan Armstrong (daughter) 8716 Groffs Mill Rd., Owings Mills, Md 21117 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Depertment of important: If any injury or Johnsville UMC Cemetery 6-29-05 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Jage Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner The lew requires that the death certificate be executed ettending physicien end I for use es the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of VItal Records, P.O. Box 68760 liabete Director: After this certificate has been signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 🗆 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Anatural 5 Pending 2 Accident investigetion 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Dete filed (Month, Day, Year)

JUN 2 8 2005

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2. Rigistrar's Signature

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30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

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E	Physici /Medic	al	Linwood Oliver C		barl		4b. City, To	um or l	continu of		June 2	26	2005 County of Death	8:30pm M
	Examin	er	4240 Salem Bottom		Del)		Westm			Death			arroll	ı
	Funeral Director		5. Social Security Number 6. Sex 1 X		7. Age (In yrs. 37	last birthday) Yrs.	If Under 1 Months	Year Days	Hours		Date of Birth (Month, Day, June 13	Year) 191	9. Birth	nplace (State or Foreign untry)
	aryland show	7	Usual Residence of Decedent 10a. State 10b. County Carrol1		10c. Ci	y, Town or Lo Westmi	cation nster							10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	vith the M or 28a-f	Directo	10e. Street and Number 4240 Salem Bottom	Road			10f. Zip Co					0g. Citize USA	en of What Co	
	death v ms 23a	nerai		12. Was Deced	dent Ever in U	.S. 13. V	Was Deceden	nt of His	panic Origi	n? (Specif	v Yes or No-		4. Race - Amer	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic evant, the Medical Examinar must be notified at ODGe.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Ford 1 Tyes 2 If Yes, Give Year or Da	₹ X No		fYes, specify I□Yes 2√X		, Mexican, I Specify:	Puerto Rio	can, etc.)	S	Black, White Specify: Wh	
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Maryland	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship (Ty) John Cavey (nephe			1						-	Town, State, Z.	
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Baltimore,	nit. Pag artment ortant: injury e		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 		Mea	adowrid 22	-						dge, Mo	d Chapel
Ä	permi Depa impo any ir		> thouse Hought		<u>ut</u>	P	.O.Box	19	5 Syk	esvil	le, Md	217	84	Chaper
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	/Medical Examiner		disease or condition resulting in death)	Due to (c	r as a consec	juence of):	110	- WC	-	1 800	0			July air
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V	xecuted and Il-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	r as a conseq	ruence of):	_							
8760,	death certificate be executed e attending physician and od for use as the burial-transit	icai		ı										
Box 6	n certific inding p use as i	n/Mec	IF FEMALE: 23b. Was decedent pregnant 2:	3c. If yes, outc			3=					23	d. Date of deliv	very
P.O. B	es that the death certifi igned by the attending be detached for use as	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2∏Feta int at time of c wn		Ectopic pregi Other (speci						Month	Day Year
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Vital	Physician: The this certificate had al director, page	Be	25. Was case referred to medical examiner?	lo anital:							Chack only on		1 🗆 Yes	2 No
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	To the Hospital or Attending within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the t ner: On the ba and mann	sis of examina	wledge, death ation and/or inv	occurred at the occurred of th	the time my opi	, date and nion, death	place, and occurred	due to the ca at the time, da	use(s) a ate and p	nd manner as lace, and due	stated. to the cause(s)
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	6		30. Name and address of person who co	1/ 1	- LA	INAI	Print)	00	- A PC	ple	Rd	we	0/27 1mil	45g 177
	Sta Registr	_	31. Date filed (Month, Day, Year))5 3 Re	gistrar's Signa	" Ago	We .		- , ,					1111

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Anna Loretta Cumming 9:00 Рм June 25 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7715 Ivymount Terrace Potomac Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 25, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 74 Yrs Washington, D.C. 577-44-3323 1931 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event. It a Medical Examination at much be notified all once. 1 ☐ Yes 2 No Directo Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 7715 Ivymount Terrace 20854 Funerai 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Mathematician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Mawhinney Anna Forsythe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18429 Cornflower Road, Boyds, Maryland 20841 Susan Jones/Daughter 20b. Place of Disposition (Name of cometery, crematory or other page of Heaven Date 20c. Location - City or Town, State 20a. Method of Disposition June 29, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland Cemetery Robert A. Pumphrey Funeral Home/Rockville, In 300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signature Funeral Servi A Licensee M00198 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Recurrent Ovarian Cancer 2½ Years Priysician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding is death), act Due to for as a posseguence of: Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physicien IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year õ Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗆 No 1 Yes 2**∑** No 1 Yes Division of Vital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the 2 Accident hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide within 24 hours a

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completely filled filled Hospitel edicai 29a. Certifier i 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D54378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd., West, Silver Spring, Maryland 20902 Cheryl Aylesworth, M.D. 31. Date filed (Month, Day, Year) 2 32. Registrar's Signature State 2005 Registrar

_			For State Registrar	State of Marylar		artment of H			ene 3. 12. 0. 0. 5	5 21239
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) CMAE CH	ANNEL				2. Date of Death Month	Day Ye	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s		1 110	4b. City, Town, or	Location of Death	lave	4c. County of I	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day,) JAN • 22,		Birthplace (State or Foreign Country)
	Director		212-38-6939 ¹ ■ Usual Residence of Decedent	M 2□F 76	Yrs.			JAN. 22,	1929 F	lorida
or Service	Show	ō	10a. State 10b. County MD Howard		ty, Town or L umbia	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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2 5	s 23a	erai [5218 Lightning View	w Road 2. Was Decedent Ever in U	10 10	2104			SA	
d 21215-0036	ntal Hygiene. event, the Medical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever In C Armed Forces? 1X Yes 2 □ No Na\ If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	City Yes or No- Rican, etc.)	Black, V	Ame <i>r</i> ican I <i>n</i> dian, Vhite, etc. White
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Maryland	5 7 5		19a. Informant's Name/Relationship <i>(Typ</i> Joan Marie Channel			ing Address <i>(Street a</i> Lightning				te, <i>Zip Code)</i> 21045
Saltimore,	S = 5		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re		cemetery, cre	osition (Name of matory or other plac National	e)		Oc. Location - City	or Town, State
altin	Departmen Importent: any njury		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licente			2. Name and Addres	s of Facility		mingeo	II, VIIGIIIA
ш	105 g g		23a. Part1. Enter the sease, or complic	ations that caused the dear	- 155	555 Twin K	nolls Roa	d, Colum		21045 Approximate
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68760	physici s the bu	edical	d.							
Division of Vital Records, P.O. Box 68760,	by the attending phatached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregn 1 Live birth 2 Fett 4 Pregnant at time of of 9 Unknown	al death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
S, P	igned by	by Pr	Part II. Other significant conditions conf	ributing to death but not res	.1		en in Part I.	23e. Did toba	cco use contribut	e to the cause of death?
ord	been si		Chronic Oh	STRUCTIVE	/ VIN	buny	V/15ease	1 Tes		Probably 4 donknown
I Rec	cate has	Completed						24a. Was an autopsy performs	24b. Were prior deat	
Vita	us certificate director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2] ER/Outpatie	nt 3 DOA Othe	26. Place of Death			
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Hospital	within 24 hours after de To the Funerel Directe completely filled in by the	ledical Ce	29a. Certifier 1 Certifying Phys. (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tim	e, date and place, a binion, death occurre	nd due to the cau	se(s) and manne a and place, and	r as stated. due to the cause(s)
Tothe	within To the comple	Me	29b. Signature and title of certifier			29c. License			I. Date signed (M	
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	101		110000	Wan 109	n 23a) (Type,	Little	Patux on t	Parks	way Col	22 2005 Vmbia MO
£.	Sta Registr		31. Date filed (Month, Day, Year) JUN 2. 8. 20	32. Registrar's Signa	ature	l				

			For State Registrar	State of	f Marylan		artment <i>tificate</i>			ind M	ental Hyg	iene 9. N2 0 ()5	21211
	Physici		1. Decedent's Name (First, Middle, Dolores Elizab		.v					1	2. Date of Deat			3. Time of Death 2:45 P M
	/Medic Examin		4a. Facility Name (If not institution, 515 Old Home Ro	give street and nun	-		4b. City, To	own, or erle		f Death		4c. County		1
	Funeral Director		5. Social Security Number 212-26-1850 Usual Residence of Decedent	5. Sex 1 ☐ M 2 ☐ ¥F	7. Age (In yrs. 74	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth	30	9. Birth Cou Mar	place (State or Foreign intry) yland
	Marylend f show	tor	10a. State 10b. County	imore		y, Town or Lo verlea	cation		1					10d. Inside City Limits 1 ☐ Yes 2☐No
	or 28e	Direc	10e. Street and Number				10f. Zip C	ode			10	0g. Citizen of	What Cou	intry?
	s 23s	ra	515 Old Home R		4.45.44	0 100			L206	7			S.a.	
036	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylend Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic svent, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed For	2 No	1	f Yes, specifi		Specify:	jin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	Bla	ck, White	
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Baltimore, Maryland 21215-0036	id be fill ental Hy ked oth ic sven	To Be	17. Father's Name (First, Middle, L. William E. Wat	-							<i>(First, Middle, N</i> Laura Do		n <i>e)</i>	
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imo	Pages nent of ant: If it		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	emetery, cren ardens	natory or oth	er place	9)	6/2				Maryland
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								WKS
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	ecuted and transit	Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				c Obst	tuct	ive l	Pulma	anary Di	sease		Yrs
8760,	icate be executed physician and the burial-transit	dicai	, and any and any		orasaconseq al Fibr		on wit	th F	Rapid	Vent	tricular	Respo	nse	Yrs
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		irth 2∏Feta ant at time of d	il death 3 □	Ectopic preg Other (spec						te of deliventh	rery Day Year
rds, P.	quires tha n signed l	d by P	Part II. Other significant condition Ostioporosis				nderlying cau	ise give	n in Part I.					the cause of death?
Records,	a law require nas been si e 2 should t	Completed	Periipheal V			Urina	ry ind	cont	inand	ce	24a. Was ar	/	prior to co	opsy findings available ompletion of cause of
	n: The ficate h or, page	e Con	Coronary Arto	ery disee	ase							₩ No	death? 1 🗌 Yes	2 KXNo
Vita	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	ER/Outpatien	t 3 DOA	Othe	_		(Check only one ne 5X Reside		er (Cono	
n of	ding Physician: The lav h. Atter this certificate has funeral director, page 2		27. Manner of Death 1 △Natural 5 ☐ Pending	28a. Date o		28b. Time of Injury		. Injury Work			28d. Describe ho			(y)
Division of	or Atten titer deat Dirsctor: in by the	Certification:	2 Accident investiga 3 Suicide 6 Could not 4 Homicide determin	ot be 28e. Place	of Injury - At h	ome, farm, stre	M eet, factory, o		'es 2□N	-	28f. Location (Str City or Town		er or Rur	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1½ Certifying (Check only one) 2 Medical E	Physician: To the xaminer: On the ba	isis of examina	owledge, death ition and/or inv	occurred at restigation, in	the tim	e, date and inion, deat	d place, a	and due to the ca ed at the time, da	use(s) and ma ite and place,	anner as s and due t	stated, o the cause(s)
)	To th withir To th	Me	29b. Signature and title of pertifier	Rei	lle	me	29c. I	License	number 749		29	d. Date signe		
	10	H	30. Name and address of person was Allen Reilly		e of death (lan	п 23а) (Туре,	Print)	Roa	ds Su	ite	307 Rali	imore.	Mar	yland 21228
	Sta		31. Date filed (Month, Day, Year)		egistrar's Signa	ature					Dull		-141	, 10.10
DL	Registr		JUN 2 8 2	2005 1900	ces h	Spa	de)							

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		1	For State Registrar		•	State of M	larylari			ent of r ate of			vientai H	ygien Reg. N	~ ~ ~ ~	212	41
Phy	sicia		1. Decedent's Name										2. Date of I	Death	ay Yea	3. Time o	1
	edica mine		Alt 4a. Facility Name (/		avi: n, give str) .		4b. C	ty, Town, o	or Locatio	on of Death	JUN		C. County of De		7 I M
			FRANKL									DAL (TIMER	
Fune Direc		2	5. Social Security N 229-20-0 Usual Residence of	714	6. Sex 1 ∑ ∤	A 2□F 7. A	ge (In yrs. i		Month	der 1 Year S Days			8. Date of E (Month, I Dec. 1	Day, Yea 2 1	924 M	Sirthplace (State (Country)	or Foreign
nyland show			10a. State MD	10b. County			1	, Town or I								10d. Inside C	•
the Ma		0109	10e. Street and Nur	Balt	TIIIOI	re		Essex		Zip Code	-			10a C	Citizen of What		2∕□ No
deeth with the Maryland me 23a or 28e-1 show	i i	2 2	327 Ic								1221	l			SA	oodiniy.	
è		by runeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		beir	. Was Deceden Armed Forces 1 Xes 2 If Yes, Give Year or Dates	?] No	S. 13		cedent of legecify Cub			pecify Yes or I o Rican, etc.)	No-	Black, Wi	nerican Indian, hite, etc. hite	
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land Jid be file Mental Hy rked oth	c	o e	17. Father's Name Leon D		Last)								ne (First, Midd		en Sumame)		
Maryland od 2 should be file the and Mental Hy 27 is marked oth	F	2	19a. Informant's Na		hip (Type	o, Print)		19b. Mai	ling Addre	ss (Street	-		Searf		or Town, State	, Zip Code)	
and 2 leelth a maz7 is		-	Dona J.		s /	wife	ant n				ve.	Balt			21221		·
nore, eges 1 au int of Hee t: If item			20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	Cremation		noval from State	ୁ ଜ	lace of Disp emetery, cri yvie	ematory c	r other pla		6	Date 25 05		Location · City of timore		
Baltimore, permit. Peges 1 as Department of Hee Important: If tem	once.		21. Signatur of Fu		-	3	11.	-	22. Name	and Addre	ess of Fa	Co	nnelly	yFun	neralHo	omeofEs	sex
Pnysici /Media	an		23a. Part1. Enter ti shock, or hea Immediate Cause disease or condition resulting in death)	(Final	complica obly one a.	tions that cause cause on each U (2) Due to (or a	NAL	24 7	nter th <i>e</i> m	ode of dyir	ng, such	as cardiac	Balt: or respiratory	arrest,	e MD 2	21221 Approximal Interval Bet Onset and	ween
68760, C. Lifficate be executed applysicien and as the burial-transit		ЕХЯ	Sequentially liet out if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	5	c.	Due to (or a	s a consequ	uence of):									
Box death cert e attendin		rnysician/medica	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2[9 Unknown	months? ⊒No	230	c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	□Ectopic □ Other	pregnancy specify) _	у				23d. Date of d Month		Year
ords, P.O requires that the een signed by the			Part II. Other signif					-		_			1	tobacco		to the cause of o	death?
Pec e law has b		Completed by	FAIL	URE									per	opsy formed?	prior to death?		available ause of
Vital Fiction: The contribute partiticate			25. Was case refer examiner?	red to medica	1								1 ☐ Yes th (Check only	one)			
of Vita Physician: this certific		2	1 ☐ Yes 2 ☑ 27. Manner of Deat		Ho	spital: 1 Impat		ER/Outpatie		Oth	ner: 4	Nursing H	ome 5 Re		6 □Other (Sp	pecify)	
ion onding Fath.			1 ☑Natural 2 ☐ Accident	5 Pendir		28a. Date of In (Month, D	ay Year)	Injury	М	28c. Injur Wor 1 🗍	rk? Yes 2	□No	200. 203010	5 110 W 111 I	ary occurred		
Division of attending F a ster death.	19161	Cermication	3 Suicide 4 Homicide	6 Could determ		28e. Place of In building, e	njury - At ho etc. (Specify	me, farm, s	treet, fact	ory, office				(Street a own, Star		Rural Route Num	ber,
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A		edical	29a. Certifier (Check only one)	1 Certifyii 2 Medical	ng Physic Examine	cian: To the bes r: On the basis and manner s	of examinat	wledge, dea tion and/or i	ith occurrences	ed at the tir	me, date opinion, d	and place, leath occur	and due to th	e cause(: e, date ar	s) and manner and place, and du	as stated. ue to the cause(s	i)
To the Within To the			29b. Signature and	title of certifie	6,	N	0			9c. Licens					ate signed (Mor	nth, Day, Year)	5 PM
10	State	Ш	30. Name and addr	M 44	1	AHTIFU 32. Res	d O d	on FE	411		Sq	LAR	E DRIV	c B	ALTINO	ce, Mo	J. 1 1 7
Reg	istra			JUN Z	8 20	15	luc	H,	door	الم							

			1- For State of Maryland / Dep Registrer Ce	artment of Health and rtificate of Death	Mental Hygier	0.0.	21212
	Physici	an	1. Decedent's Name (First, Middle, Last) John W. Daniels		2. Date of Death	Day Year	3. Time of Death
	/Medic	al	John W. Daniels 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	June 22.	2005 4c. County of Death	6:15 A M
	Examin	er	517 W. 28th Street	Baltimore	tri	N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 17-84-2961 Yrs.		. (Month, Day, Ye	ar) 9. Birth	place (State or Foreign ntry) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show	ctor	Maryland N/A Balti	more			1 Nes 2 No
	or 28	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	eath v	Funerai	517 W. 28th Street 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origins (S	Specify Vac or No.	USA 14. Race - Ameri	oon Indian
030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depstranet of Health and Merial Hygiene. Depstranet of Health and Merial Hygiene. Importent: if item 27 is marked other than "naturel; or items 23a or 28e-f show any injury or other treumetic event, it is Medical Exact instituted at ance.	by	Amed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 3 Widowed 4 Divorced Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes XX No Specify:	to Rican, etc.)	Black, White,	etc.
15-0036	n 72 ho "natur edicell	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation a kind of work done during most of wo DO NOT use retired)	rking 16b	. Kind of Business/In	dustry
7 7 7	d within giene. ir than "	omo	Elementary/Secondary (0-12) College (1-4or 5+)	ndscaper	La	andscaping	2 Company
and	be filed fal Hyg d othe event,	Bec	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid		s company
5	should I ind Meni is marked	ပို	John C. Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Maili		Dotson		
<u> </u>	nd 2 si lith an 27 is r r treur		1 = .	ing Address (Street and Number or At W. 28th Street Ba	altimore, Cit		
ore,	of Health of Health litem 27		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)		Location - City or To	
Ĕ	Pages Iment of tent: If it		4 Donation 5 Other (Specify) Baltimore	_ 1.7 _ 1	3/2005 I	Laurel Mar	yland
Baltim	permit Depsr impor any in		21. Signature of Funeral Service Licensee 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not en	Name and Address of Facility	z Funeral H	Home, Inc.	21211
		5	shock, or heart lande. List only one cause on each life	ter the mode of dying, such as cardiar	c or respiratory arrest,	MD	Interval Between
ì	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	nonja			Poset and Death
	Examiner		Due to (or as a consequence of):				
H	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		-		
Ď,	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last				
08/PN	ficate by physic as the bu	edicai	d				
C. BOX	that the death certifics ed by the attending ph detached for use as t	hysician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
ras, r	w requires that the s been signed by th should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
ecora	~ Q 70	Completed			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
Z a	sicien: The taw certificate has l				performed	death?	2 No
VItal	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FP/Outpatien	Other	ath (Check only one)	6 ☐Other (Specifi	14)
Ion or	nding Phys tth. r: After this e funeral di	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how in		<i>n</i>
DIVISION	To the Hospitei or Attending within 24 hours after death. To the Funerei Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St.	and Number or Rura ate)	l Route Number,
	ne Hospit 24 hour ne Funere	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occurrence.	e, and due to the cause arred at the time, date a	(s) and manner as si and place, and due to	tated. the cause(s)
	To ti To ti comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)	01	une 2	3,2005 21202
)		30 St. Pau Sut 31. Date filed (Mopth, Day, Year) 32. Registrar's Signature	e 401 Bo	ultimor	e, MD	21202
	Sta Registr		JUN 2 8 2005	· · · · · · · · · · · · · · · · · · ·			

			For	State of Marylar	nd / Depa	artme	nt of H	ealth ar	nd Me	ental Hyg	jiene	Legible.		
			1 - For State Registrar		Cei	tifica	te of L	Death				2005	21243	
П	Physici	an	Decedent's Name (First, Middle, Las	t)		0.4				2. Date of Dea Month	Day	Year	3. Time of Death	
5	/Medic	al	SHIRLE (4a. Facility Name (If not institution, give	street and number)	_			Location of		TUNE		County of Dea		
	Examin	er	THE JOHNS H		147592			imore			40.	N/A		
	Funeral		5. Social Security Number 6. Se		. last birthday)	If Unde	r 1 Year Days	If Under 24 Hours	4 Hrs. 8	B. Date of Birth	Year)		hplace (State or Foreign ountry) aryland	n
	Director		Usual Residence of Decedent	J	Yrs.					Jan U.	Ι,	1936	aryland	_
	yland how		10a. State 10b. County		ity, Town or Lo								10d. Inside City Limits	
	Be-1 s	ctor	Md. Baltir	nore	Rosed								1 ☐ Yes 2 ☐ No	1
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show mimportant: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic event, the Madical Examiner must be notified at once.	Funeral Director	10e. Street and Number 8517 Philade	elphia Rd.		10f. Zi	p Code 2	1237		1	0g. Citiz	zen of What Co	S A	
	death	nera	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. \	Was Dece			n? (Spec	ify Yes or No- ican, etc.)	1	14. Race - Ame	ncan Indian,	_
98	or ite	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give		ryes,spe 1 □ Yes		Specify:	Риепо н	ican, etc.)		Black, White Specify: W	e, etc. hite	
Maryland 21215-0036	ture!	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Deced	lent's Usi	al Occupa	ition				nd of Business		_
215	thin 72 B. "ne M. d. "	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of w DO NOT L	ork done d ise retired,	uring most o	of working	7				
2	fited will Hygien other th	Con	17. Father's Name (First, Middle, Last)		Sa1	es		40. 11. 11. 14	. Nie			Retail		_
anc	d be fi	To Be		A. Hanna					s Name≀ 'iam	First, Middle, I Wils		Sumame)		
ary	should Ind Men	Ĕ	19a. Informant's Name/Relationship (7					nd Number	or Rural i	Route Number	r, City or	Town, State, 2		_
	and 2 ealth a m 27 is		Kenneth Dahlstr					elphi	a R					
ore	Pages 1 nent of H ant: If ite ury or oth		20a. Method of Disposition 1 ★ Bunal 2 □ Cremation 3 □	Removal from State	Place of Dispo- cemetery, cren	natory or	other place	'	Dar			cation - City or		
Baltimore,	artmer ortant injury		* 4 □Donation 5 □ Other (Specify 21. Signature of Fugeral Service License		eulah 22								ille, Pa.	_
Ba	Depa impo any i		· Lel.	12	1	686	Yor	son t	une	ral Ho wson,	'Ma:	2120	4	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that caused the dea	th. Do not ente	er the mo	de of dying	, such as ca	ardiac or	respiratory arre	əst,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a5	EBZ.	IS							Onset and Death	
	/Medical Examiner			Due to (or as a consec	quence of):	7 =	1 6	= () () =	- 1= 1	ATA			1	
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec		1 10	<u> </u>	2017	· 1-	-2 14			1 year	_
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C									· · · · · · · · · · · · · · · · · · ·	
760,	ate be executed hysician and the burial-transit	cai E		Due to (or as a consec	quence or).									
89	tificate ng phy: as the			d										_
Вох	ath cer ttendir or use	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	al death 3□	Ectopic p	regnancy				2	3d. Date of deli	very Day Year	
0	The law requires that the death certifica tite has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of o	death 5□	Other (s _i	pecify)					WORTH	Day Toal	
О.	signed by	y Ph	Part II. Dther significant conditions co	ontributing to death but not re-	sulting in the un	nderlying	ause give	n in Part I.		23e. Did tob	acco us	se contribute to	the cause of death?	_
Records,	w require been sig should b							<u>. </u>		1 □ Ye	is 2	₹46 3□Pr	obably 4 Unknown	
ĕ	e lawr has be	Completed							_	24a. Was ar autops	y	prior to d	topsy findings available completion of cause of	
a	ician: The law certificate has rector, page 2 (25. Was case referred to medical								No.	death? 1 🗆 Yes	2 □ No	
\geq	y 8	o Be	examiner?	Hospital: 1 Impatient 2] ER/Outpatient	1 3 D	Othe	r		Check only on 5 ☐ Reside		□Other (Spec	rify)	
0 _	ding Phys h. After this funeral di	On; T	27. Manner of Death SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	at ?	28	d. Describe ho				
Division of Vital	Attending r death. sector: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be		ome farm stre	M factor		es 2 □ No		f Location (St	reet and	Number or Ru	ral Route Number.	
^		Certification;	4 Homicide determined	building, etc. (Speci	fy)	301, 180101	y, omca			City or Town	, State)	778.11001 07 770	ai nobio Nambor,	
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in its completely	edicai (29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my knoiner: On the basis of examina	owledge, death	occurred	at the time	e, date and p	place, and	d due to the ca	iuse(s) a	and manner as	stated.	_
	To the within 2. To the complete	Med	one) 29b. Signature and title of certifier	and manner stated.			c. License					signed (Month		_
	- 3 - 3		1	FELLOW				584	75				2005	
	6		30. Name and address of person who c	completed cause of death (Iter		Print)								
	<i>J</i>		PHILIP MINATPU 31. Date filed (Month, Day, Year)	32 Agristrar's Sign	RTH W	10LE	E 5	TREET	T , B ,	ALTIM	٥٨٥	, MD 2	11287	
	Sta Registr		JUN 2 8 20	32 Registrar's Sign	& Apr	we								

			. For	State of							ental Hy					
			- State Registrar			Ce	rtificat	e of L	Death			Reg. No.	005	- 2	212	44
П	Physici		Decedent's Name (First, Middent TAMARA	dle, Last)			חלח	ΛΝΛς	нуті т		2. Date of De Month June	Day 2	Yea 200	ر _ح	3. Time (4 SAM
	/Medic Examin		4a. Facility Name (If not institution						Location of		Jarre	4c.	County of De		<u> </u>	
		4		of Baltin			If Under		lore		1			/A	/2:	
Г	, Funeral Director		5. Social Security Number 214-94-5687	6. Sex 1 □ M 2 X F	'. Age (In yrs. 80		Months	Days	Hours	Min.	8. Date of Bir 12/29/	1924	0F	Countr GF	SREPI ORGI	JBLIC A
	pu *		Usual Residence of Decedent 10a. State 10b. Count	v	10c Cit	y, Town or Lo	ocation									City Limits
	ours after death with the Marylan ral', or Items 23c or 28a-f show Examirer must be no lifted at	tor	MD BALTIN	•		VENSON								10		s 21/2 No
	th the	by Funeral Director	10e. Street and Number				10f. Zip	Code	_			10g. Citi	zen of What	Countr	y?	
	s 23c	ral	1505 NEAR TH			0 10		153		: - 2 (0	·*4.24 N		U.S 14. Race - Ar		- 1-4:	
(0	r Item	Fune	11. Marital Status 1 □ Never Married 2 🔀 Ma	12. Was Deced	es? 2 X No	i					city Yes or No lican, etc.)		Black, W	hite, et	tc.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23c or 28a-1 show the Modical Examirer must be notified at		3 Widowed 4 Divorce	ed Year or Da)		1 Yes		Specify:				Specify: W			
15-(in 72 h	olete	(Specify only high	ent's Education est grade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done c	durina mos	at of workin	g	16b. Ki	nd of Busine:	ss/Indu	ıstry	
212	filed with Hygiene. other than	Completed	Elementary/Secondary (0-12)	College (1-	40r 5+)	OB/GY	N REG	ISTE	RED N	NURSE		HEAL	THCAR	Ε		
pue	ould be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle BENZION	e, Last)	D.	ZHANAS	шитет			er's Name CHEL	(First, Middle,	Maiden		ΕМΛ	CHVII	т
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M	2	19a. Informant's Name/Relation	nship (Type, Print)	υ.	1		(Street a		_	Route Numbe	er, City o			SHVII Code)	_ 1
_	rif. Pages 1 and 2 should be filed within 72 ho entrent of Health and Mental Hygiene, ortant: If Item 27 Is marked other than "natur mjury or other traumatic event, the Widdeal 8		DAVID DZHANAS	SHVILI/HUSB		_					7-BALT		-			
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 D Burial 2 Cremation		tate 1	Place of Disponentery, cre					Ate Annual		cation - City			
altin.	permit. Page Department of Important: If any injury or once.		* 4 □Donation 5 □ Other (CHE	VRA AH					/2005 LEVINS		DALLST BROS			
ñ	permit. Departr Imports any inju		> (Jayllla	y Lew							DAD - F					208
			23a. Part1 Enter ne disease, show, or heart failure. Lis	^					1 1	-	respiratory a	rrest,			Approxima Interval Be Onset and	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Aci	nte M	yoca	rdial	10-	arct	100				1.3	8 dc	145
	Examiner		Conventially list and distance	Ather	oscle	rotic	Hea	rf	Dise	ase	_			2	204	jears
14	pe lis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	r as a conseq	uence of):										
6	te be executed ysician and te burial-transit	cal Examiner	that initiated events resulting in death) Last	c. Due to (c	r as a conseq	uence of):				_				-		
3760,				d												
x 68	The law requires that the death certifica tite has been signed by the attending ph page 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE:	23c. If yes, outc	ome of precon	ancv							22d Data al d	delivee		
Box	death of attended for up	Ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live bir 4 ☐ Pregna	th 2 ☐ Feta int at time old	Ideath 3[⊒Ectopic pr ⊒ Other (sp					1	23d. Date of o Month		y Day	Year
P.0	at the	Phys	9 Unknown	9□ Unkno												
	signed bed	1 by	Part II. Other significant condi	tions contributing to dea	ath but not res	uiting in the t	anderlying c	ause givi	en≀ntPantl	١.	23e. Dig t		se contribute			Unknown
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l Re	The la ate ha: page 2	Somp										osy ormed2 _2 \ No	prior t death	?	pletion of	cause of
of Vital	ician: certific ector,	Be	25. Was case referred to medic examiner?	Hospital:				Oth	or:		(Chack only o					
of	Phys ar this aral dir	1; To	1 ☐ Yes 2 € No 27. Manner of Death	28a. Date o		ER/Outpatie		28c. Injun	4 - 140		ne 5 ☐ Resi 8d. Describe			oecify)		
ion	ending sath. or: Afte	atlo	E DAGGOOM	stigation	i, Day Year)	Injury	М		Yes 2	No						
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Coul 4 Homicide dete	mined 286. Place	of Injury - At high etc. (Specif	ome, farm, st	reet, factor	y, office		2	8f. Location (City or To			Rural .	Route Nu	mber,
	spital	al Ce	29a. Certifier 1 Certify	ring Physician: To the	best of my kno	wiedge, dea	th occurred	at the tin	ne, date an	nd place, a	nd due to the	cause(s)	and manner	as sta	ted.	
	the Ho in 24 I the Fu	ledical	one)	al Examiner: On the ba and mann	sis of examina er stated.	ition and/or ir				ath occurre	d at the time,					
	To vith	Σ	29b. Signarure and title of certif	es la Pa	Dh-	M.D		c. Licenso	e number				e signed (Mo			
	3		30. Name and address of person				7							-/	2-0	
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ORIGINAL

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			Registrer 1. Decedent's Name (First, Middle, Last)				2. Date of Death	Pak Yaar	3. Time of Death
	Physici /Medic	al	CAROLY	N FLOWE	· · · · · · · · · · · · · · · · · · ·		JUNE	24 200: 4c. County of De	5 0.30 M
	Examin	er	4a. Facility Name (If not institution, give si	CHIE HOSPICE	45. City, 1000, of	TIMOKE		4c. County of De	au1
	Funeral Director		5. Social Security Number 215.30.8156 Usual Residence of Decedent	M 201F 7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. BI	rthplace (State or Foreign country) AKY LAND
	iryland show		10a. State 10b. County	10c. City, Town or	0				10d. Inside City Limits
	the Ma 28a-f s	Director	10e. Street and Number		TIMOKE 10f. Zip Code		100	g. Citizen of What C	1 Tyes 2 No
	23a or	raiDi	7107 RUTHER	FORD GREEN C	R.	21244		U.S.	A:4
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of H If Yes, specify Cyba 1 Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Am Błack, Wh Specify:	
2-0	72 hou "nature	eted	15. Decedent's Educ (Specify only highest grade	completed) (Gi	cedent's Usual Occup	during most of working	g 16	6b. Kind of Busines	s/Industry
2121	d within giene. or than	Completed	Elementary/Secondary (0-12)	College (1-for 5+)	. DO NOT use retired SPECIA			SOCIA	1 WORK
Maryland 21215-0036	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) ELMER W	. GERMAN		18. Mother's Name	(First, Middle, Ma L12A	aiden Sumame) NOBIN	sow
Man	d 2 should th and Men t7 is marke traumatic		19a. Informant's Name/Relationship (Type)	DERS (DAVBHTER) 710	- D.	and Number or Rural	Route Number, C		Zip Code) 10, MD 21244
ore,	es 1 and of Health If Item 27 or other tr		20a. Method of Disposition 1 Burial 2 Deremation 3 Re	20b. Place of Dis	position (Name of rematory or other place	ce)		c. Location - City o	r Town, State
Baltimore,	Ly Fig. Pa		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	GREENMO	WY CREMA 22 Name and Address	toky 6.2	1.05 B	MTIMORE	MAYLAND TUNCKAC HIM
	permit. Departn Importe any inju		1 Vaupa	Drune	1905 YIK	CK ROAD	BATIM	OKE, MAZ	YLAND 21212
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	,	_			Approximate Interval Between Onset and Death
	/Medical	07 1	disease or condition resulting in death)	CHEWIC 0 65 Due to (or as a consequence of):	RUCTIVE	TUCHONA	RY DI	SEASE	10 YEARS
7	Examiner	er	Sequentially list conditions, Tary leading to immediate cause. Enter Underlying	Due to (or as a consequence of):					
	acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	·					
8760,	cate be executed physician and the burial-transit	dicai Ex	d d	Due to (or as a consequence of):					
ဖ	ertificate ing phy e as the	Medic	IF FEMALE:						
Вох	death certific a attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	4 Pregnant at time of death 5	B □Ectopic pregnancy			23d. Date of de Month	elivery Day Year
P.O.	that the de led by the a detached f	Phys	9 Unknown Part II. Other significant conditions con-	9 Unknown		on in Boot !	23a Did toba	and use contribute	to the cause of death?
rds,	Se Ligo	ed by	BIPOLAR DIS	CORDER, HYI	ERTENS	10N			robably 4 Unknown
Records,	ie law require has been sig ge 2 should b	Completed					24a. Was an autopsy	n prior to	autopsy findings available completion of cause of
			25. Was case referred to medical			00 81	perform 1 Yes 2	death? ANo 1 ☐ Ye	s 2□No
f Vital	yslcian: nis certific I director,	To Be	avaminar?	ospital: 1 Inpatient 2 ER/Outpati	ient 3 DOA	er: 4 ☐ Nursing Hom		ce 6 Other (Sp	ecity) Hospice
ouo	ding Phy h. After thi funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time (Month, Day Year)	/ Wor	yat 28 k? Yes 2 □ No	8d. Describe how	injury occurred	
Division of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifico completely filled in by the funeral director.	Certification;	2 Accident Investigation 3 Suicide 5 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)			Bf. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
<u>α</u>	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, de	ath occurred at the tin	ne, date and place, ar	nd due to the cau	se(s) and manner a	is stated.
	the Ho hin 24 I the Fu npletely	Medical	onej	er: On the basis of examination and/or and manner stated.	investigation, in my o			e and place, and du	
}	Tw To		29b. Signature and title of certifier	(
	10 4		30. Name and address of person who con	mpleted cause of death (Item 23a) (Typ	e, Print)	2		A . A ~	21045
	Sta	te	31. Date filed (Month, Day, Year)	- JZ. Pagistial S Signature		RE, CO	CUMBI.	A MD	21045
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James Felder 05-0420 CJS

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. N2 0 0 5 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** June 2005 10:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2537 Quantico Avenue **Baltimore** Baltimore County If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 1**X**M 2□F Days Hours 2J636-5209 Usuel Residence of Decedent Director with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic evant, the Medical Examinar must be notified at 1 Ses 2 No Be Completed by Funeral Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death 13. Was Deceden Race - American Indian, Black, White, etc. 11. Marital Status Ever in U.S. nt of Hispanic Origin? (Specify Yes or No-y Cuban, Mexican, Puerto Rican, etc.) med Forces?
Yes 2 No
Yes, Give
ear or Dates: 1 Never Married 2 Married 1 TYes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. dary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) ed bluods Method of Disposition permit. Pages Department of Pimportant: If its any injury or of once. **Y**Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Eun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** atheroscleration CardioVascular /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to (or as a consequence or) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Physician/Medicai as the L IF FEMALE esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by pe 1 Yes 2 No 3 Probably 4 Únknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 death? 2□No Yes or Attanding Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) at scene 1 😾 Yes 2 🗌 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation after death. 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel
within 24 hours a
To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) OCME June 23, 2005 and address of person tho completed cause of m 23a) (Type, Print) Baltimore, Maryland 21201 111 Penn Street OLHAK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death **Physician** Month Rufus Flood June 2005 9:55a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Chapel Hill Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 18 09 Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1፟**X**M 2□F Director 95 Yrs. 218-05-7907 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at Director MYes 2 ☐ No MDNA Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 3520 Langrehr Road 21244 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2√XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: δ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Domino Sugar Co. <u>8th grade</u> na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fi lealth and Mental F Benjamin Flood Lucille Archer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a: If item 27 is 3143 Jeffland Road, Baltimore, Md 21244 Pauline Turner=Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XIXBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Maryland National | 6/25/05 Laurel, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature in Funeral Service L Baltimore, Md 21215 Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or heart failure. List only one muse on each line. THEROSCHEROTIC Imr diate Cause (Final dis se or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending I 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Lonknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No his certificate has bit director, page 2 sl 24a. Was an autopsy performed? 1 🗌 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 ☑ No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EP/Outpatient 3 DOA To the Hospitel or Attending Physiwithin 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23/01 serellu 30. Name and address of person who completed cause of death (Item 23a) (Type, Printy) AKHAN, TASNEEm 7220 31. Date filed (Month, Day, Year) 2005 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sophie Figura 2005 June 2:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Baltimore Towson 8. Date of Birth (Month, Day, Year) June 18, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 85 Yrs. 578-18-4679 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits th and Mental Hygiene. 7 is marked other then "neturel", or liems 23a or 28a-f shov treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1934 Church Road Funeral 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail - Clothing Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Chavt Ida Bernstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 1934 Church Road Dundalk, Maryland 21222 Jacob S. Figura, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Importent: If ite eny injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 06/24/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Lymphoma (reers /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Taxas (Lisas of injuly that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an cate has to autopsy performed? certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check on one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Notes 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel of within 24 hours at To the Funerel D completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24 2005 D58303 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAREN CHAMIRSWO 6001 N-Charles St tows in 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 8 2005 Registrar

awa, Johnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ERNEST)UN 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard County General Hospital Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 25 1936 Birthplace (State or Foreign
Country) **Funeral** Days Hours 1**X** M 2□ F 217-36-2631 Director Md Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exam are must be faulthed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Howard Svkesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1026 Taylor Park Road 21784 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

19 Yes 2 □ No 1957—
17 Yes, Give
Year or Dates: 1966 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security claims representative 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest James Frank Sr. Georgia Melson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Frank (spouse) 1026 Taylor Park Rd., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 6-30-05 Glen Burnie, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Page Hought Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): HEMICO LECTURA Examiner RIGHT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner as the burial-transit The law requires that the death certificate be executed the attending physician and Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 101 in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 No 1 Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2√ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. the Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signative and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO0 56948 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET SMITMONE ACURAN 522 DolphiN 32 Registrar's Signature 31. Date filed (Month, Day, Year) 8 2005 Registrar

	1	For State Registrar	State of Maryland			of Health a		-	giene	21250
Dhuaisia		1. Decedent's Name (First, Middle, Last)						2. Date of De Month	ath	3. Time of Death
Physicia /Medica	ai -	Nell A. Fields						June 24	4,2005	5:30 Ам
Examine		4a. Facility Name (If not institution, give str	reet and number)		4b. City, To	wn, or Location	of Death		4c. County of D	eath
		1607 Jennings Rd. 5. Social Security Number 6. Sex	7. Age (In yrs. last	highday	Glen I	Burnie Gear If Under	24 Hrs	8. Date of Bir	Anne Ar	
Funeral Director			M 2∏F 84	Yrs.		ays Hours	Min.	(Month, Da Feb 19		Birthplace (State or Foreign Country)
g		Usual Residence of Decedent						reb 19	• 1921 Re	ntucky
arylar show	_	10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits
he M	Director	MD Anne Arun 10e. Street and Number	del Glen	Burn						1 ☐ Yes 21 No
with with the or of					10f. Zip Co				10g. Citizen of What	
ING 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. d other than "natural, or items 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral	1607 Jennings Rd.	2. Was Decedent Ever in U.S.	13. \	2106 Was Deceden	t of Hispanic Or	rigin? (Spe	cify Yes or No	United St	ates merican Indian,
or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No	1	f Yes, specify	Cuban, Mexica	n, Puerto I	Rican, etc.)	Black, W	hite, etc.
ours ours	g	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2🏋	No Specify.	:		Specify: V	White
21215-0036 dd within 72 hours af gjene. tra Madical Exam	Completed	15. Decedent's Educa (Specify only highest grade	ation 1 completed)	(Give	tent's Usual C kind of work	loné durina mos	st of workii	ng	16b. Kind of Busine	ss/industry
withir sale.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use i	etirea)				
d 2 Hygid Sther ant, I		17. Father's Name (First, Middle, Last)		нотет	naker	18. Moth	er's Name	(First, Middle	Home Maiden Sumame)	
Maryland d 2 should be file th and Mental Hy th and Mental Hy th and marked oth traumatic event	To Be	Schuyler Thomas Ha	milton			Etta	a Mae	Beamar	1	
ore, Marylanc es 1 and 2 should be fi of Health and Mental I fitem 27 is marked ot r other traumatic ever		19a. Informant's Name/Relationship (Type		9b. Mailin	g Address (S		-		er, City or Town, State	e, Zip Code)
C 101 L		Mary Taylor / Dau	ghter	1306	Gatwio	k Rd. 0	Glen	Burnie,	, MD 21061	
Baltimore, Dermit. Pages 1 a Department of Hee Important: If Item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place ceme	of Dispo	sition (Name natory or othe	of r place)		e 27,	20c. Location - City	or Town, State
Pages ment of mrt. If it		' 4 □ Donation 5 □ Other (Specify)		Haver	n Memor	ial Par		2005	Glen Bur	nie, MD
Baltimo permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee		22	. Name and A Kirkle	ddress of Facili	ity Lck F	uneral	Home, P.A	
20 = 8 Q		Mux COA	wal		421 Cr	ain Hig	ghway	S.E. (Glen Burni	e, MD 21061
1		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final	cause on each line.						rrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	C010	N	CA	NCZN	<			142
Examiner			Due to (or as a consequen	Ce of):	-	NCZN M=11.	1. the	300		ure
THE REAL PROPERTY.	je.	Sequentially list conditions, it any leading to immediate	Due to (or as a consequent	ce of:	73 /	121/	I V us	J		7-5
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Hy	Po 7	2, 1010	dison				425
e exe		resulting in death) Last	Due to (or as a consavian	ce of):						
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d.								
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cords * requires been sig								1 🗆	Yes 2 No 3□	Probably 4 Unknown
Records, he law requires t a has been signe ge 2 should be o	Completed							24a. Was	an 24b. Were	autopsy findings available
	Eo							autor perfo	promed? death	
Vital F	Be	25. Was case referred to medical examiner?				26. Place	e of Death	Check onl		
Of V Physic this ce	၉	1 ☐ Yes 2 No		Outpatien			ursing Hon	ne 5 X Resi	dence 6 Other (S	pecify)
Division of to Attending Phy after death. Director: After this in by the funeral d	Certification;	27. Manner of Death 1 ★ Autural 5 Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury		Injury at Work?		28d. Describe	how injury occurred	
ISIC ttend death death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be	290 Place of Injury - At home	form ot	M	1 □ Yes 2 □		19f Logation /	Street and Number or	Dural Davida Alumbar
Div A after Direct Dire	ertif	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, rarm, str	eet, factory, o	пісе	2	City or To	Street and Number or wn, State)	Hurai Houte Number,
irs is		29a. Certifier	cian: To the best of my knowle	dge, death	occurred at t	he time, date ar	nd place, a	and due to the	cause(s) and manner	as stated.
n 24 h	edical	(Check only 2 Medical Examine one)	er: On the basis of examination and manner stated.	and/or in	vestigation, in	my opinion, dea	ath occurre	ed at the time,	date and place, and o	lue to the cause(s)
To the within To the comp	ž	29b. Signature and title of certifier	7/		_	icense number			29d. Date signed (Me	onth, Day, Year)
		C)/	16		0	1475	1		6/24/	05
3		30. Name and address of person who con) · 1		01010	
		Thomas C. Folke 31. Date filed (Month, Day, Year)			stal Co	urt 1	asad	ena, MI	21012	
Stat	e ir	JUN 2 8 200	32. Fegistrar's Signature	1	osele					

			1 - For State Registrar	State of Marylan	•	artmen			nd M		jiene	05	21251
	Director)		1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month		U J	3. Time of Death
	Physicia /Medio			abbey		,				June 2	1, 200	5 Year	7:30 am ^M
	Examin	er	4a. Facility Name (If not institution, give s Franklin Square					Location of	f Death			ty of Dea	
	Funeral		5. Social Security Number 6. Sex	· · · · · · · · · · · · · · · · · · ·	last birthday)	If Under	seda 1 Year	If Under 2	24 Hrs.	8. Date of Birth		1 timo	thplace (State or Foreign
1	Director			M 2 € 90	Yrs.	Months	Days	Hours	Min.	Nov. 9	, 1914	C	yland
	land bw	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary I-1 sh	tor	Maryland Baltimore		Parkv-	ille							1 ☐ Yes 2 No
	th the)irec	10e. Street and Number			10f. Zip	Code				l 0g. Citizen o	f What Co	ountry?
	ath w	ral	8830 Walther Blvc		-	212					USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show ship injury or other traumatic event, if a Model Examination intelligible at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	Was Decedent Ever in U Armed Forces? □ Yes 2 X No If Yes, Give		Was Deced If Yes, spec 1 ☐ Yes 2	ify Cuba	spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto i	cify Yes or No- Rican, etc.)		ack, Whit	
9	2 hour	ted t	15. Decedent's Educ		16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of		/Industry
215	thin 72 9. An "na	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired,	lu <i>ring m</i> ost)	of worki	ng			,
7	ed wil ygien ner th	Соп			Accou	unting	Sup						vernment
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lan,	2 sho and i is mu		19a. Informant's Name/Relationship (Typ	*						l Route Numbe			
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nor	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro '4 ☐ Donation 5 🛣 Other (Specify)	emoval from State	^{semetery, crei} Laney V	matory or o	ther place	· 1	. 6/	24/05			Maryland
Baltimore,	permit. F Departmi Importar eny injur	: [21. Signature of Funeral Service Liminse		22	2. Name an	d Addres	s of Facility	,		105	O Yo	rk Road
Ö	Depared Important Importan		las d.	engel	R	Ruck T	owsc	n Fun	eral	Home,I	nc.Tow	son,	Md. 21204
	Pnysician		23a. Part1. Enter the disease, o complishock, or heart failure. Lift only on Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.	h. Do not ent	er the mode	e of dying	g, such as o	cardiac o	r respiratory ari	est,		Approximate Interval Between Onset and Death
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3876	icate t physic	dical	- 0									-	
Box 6	death certific e attending p ed for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna							23d. D	ate of de	livery
P.O. B	0 0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown		Ectopic pro Other (sp					٨	Month	Day Year
	res that thigned by	by Pf	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use co	ntribute Id	the cause of death?
ord	w require been sig should b	ted t	AKI, HTIV							1 □ Y	es 2 🗆 No	3 🗌 Pr	robably 4 Unknown
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₹	Physician: r this certificatal director.	To Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient	ER/Outpatier	nt 3 DO	A Othe			Check on or		than (C	- F.O.
of	g Phys ter this neral di		27. Manner of Daath	28a. Date of Injury (Month, Day Year)	28b. Time o		8c. Injury Work	at		8d. Describe h			city)
sior	uttandin death. ctor: Al y the fur	atio	1 Natural 5 Pending investigation	(Month, Day 10an)	пцагу	М		res 2 🗆 N	10				
Division of Vital Records,	afor Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, sti fy)	reet, factory	, office		2	8f. Location (S City or Town		nber or Ru	ural Route Number,
	To the Hospital or Attanding I within 24 hours after death. To the Funaral Director: Atter completely filled in by the funer	Medical C	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	ician: To the best of my knoter: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	i place, a	and due to the co	ause(s) and r ate and place	nanner as , and due	s stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			290	License	number		2	9d. Date sign	ed (Mont	h. Day, Year)
			1 ()			<u>(1</u>	173	115			jun	23'	2005
	8		30. Name an vado ss of person who co	mpleted cause of death (Item	п 23a) (Туре, ∽ <i>О</i>	Print)	i	10 H	Hu	BI-	J fo	~ F~	200F
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature do	ule							· · · · · · · · · · · · · · · · · · ·
	State 31. Date filed (Month, Day, Year) State Registrar State 31. Date filed (Month, Day, Year) State 31. Date filed (Month, Day, Year) State 32. Date filed (Month, Day, Year) State 33. Date filed (Month, Day, Year) State 34. Date filed (Month, Day, Year) State 34. Date filed (Month, Day, Year)												

				C	Certificate o	f Death		Reg. 200	15 2	2125
	Dia		Decedent's Name (First, Middle, Last)				2. Date of D	eath		3. Time of [
	Physici /Medi		Evelyn Gray				(C)	26 i	Yeer	2:15
1	Examir		4a. Fecility Name (If not institution, give street and number)			4b. City, Town, or I	ocation of Dea	th 4c. County	of Death	
			HCR Manorcare			Wheaton		M ont	gomer	v
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birtho	day) If Under 1 Yea Months Dey	ar If Under 24 Hrs.	8. Date of B (Month, D	irth	9. Birthpla	ice (State or y)
	Director		577~58~5634 1□M 2\\ F 87	Yr	s. Williams Boy	Tiodis IVIII.		17, 1918	Abel.	Ľ. MD.
	and *		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town o	or Location				10	d Incide Cit
	anyla sho	5							100	d. Inside City 1
	he N	Sch	DC	Washi	ngton					
	with w	ā	1362 Tuckerman Street N.W.		10f. Zip Code	•		10g. Citizen of V	Vhat Countr	у?
	s 23	erai		in 110	20011	(11)	7 1/	USA		- 4- 41-
_	iter d	Funeral Director	11. Marital Status 12. Was Decedent Ever Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	III U,S.	If Yes, specify Cu	f Hispanic Origin? (Sj uban, Mexican, Puert	o Rican, etc.)	Blac	e - Americar ck, White, et	n indian, ic.
Maryland 21215-0020	s 1 end 2 should be filed within 72 hours efter death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28a-f show other treumatic event, the Medical Evartnet must be notified at	2	3 Midowed 4 Divorced Year or Dates:		1□ Yes 2⊠N	o Specify:		Specify	Blac	k
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<u>a</u>	rid be Fenta Ked	TO B	William H. Hall			Estella	Collin	ıs		
ar	shot ind N	-	19a. Informant's Name/Relationship (Type, Print)	19b. N	failing Address (Stre	et and Number or Ru	rei Route Numi	ber, City or Town,	State, Zip C	code)
	aith a 27 ls		Gwendolyn Gray-Clark/Daughte:	r 1362	2 Tuckerma	an St. N.W	Washi	naton T) C 2	0011
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altimore,	permit. Pag Department Important: If any injury o		21. Signature of Funeral Service Licensee		22. Name end Add	lress of Facility Ma				e
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Ę	ysicien: The is certificate director, pag	Be	25. Was case referred to medical examiner?			26. Place of Dea	th <i>(Check</i> only	опе)		
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Division of Vital Records,	or At offer of or Direction by	T.	4 Homicide determined 28e. Place of Injury - building, etc. (Sp.	At home, farm pecify)	, street, factory, office	Θ		(Street and Numb own, State)	er or Hurai F	Route Numb
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	o the o the omple	₹ E	29b. Signature and title of certifier		29c. Lice	nse number	T	29d. Date signed	d (Month, Da	ay, Yeer)
	⊢ ≯ F ŏ		Marita Ctamina	11/	M	12910	0	1/1	10-	
	6		30 Name and address of person who completed cause of death	(Item 23a) (To	ne Print)	V 0 1 1 8	۵	6/96	105	
	Ψ		Louise Stomierowski, MD. 11			nuo Lihaata	m 1670	20000	1	
			,, 11		PTG HAGI	ine Milearo	ш, МД).	20902		

32. Egistrer's Signature

ise contribute to the cause of deeth? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? ĺΝο 1 ☐ Yes 2 ☐ No ☐Other (Specify) occurred Number or Rural Route Number, and manner as stated. place, and due to the cause(s) signed (Month, Day, Yeer)

Approximate Interval Between Onset and Death

2:15A.M.

Birthplace (State or Foreign Country)

10d. Inside City Limits 1⊊ Yes 2□ No

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 8 2005

Physici /Medi		1. Decedent's Name (First, Middle, Last) Emmanue		rtificate of Death	2. Date of Death Month	Pay 2005	3. Time of Dea
Examir			pital	4b. City, Town, or Location of Deat Baltimere City	h	4c. County of De	eath
uneral irector		5. Social Security Number 6. Sex 1\overline{X}M 2 \sqrt{F} Usual Residence of Decedent	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.			Birthplace (State or Fo Country) iberia
Ba-f show	ctor	MD 10b. County 10b. County Prince Georg	es Col	cation Llege Park			10d. Inside City Li 1 ☐ Yes 3
If itsm 27 is marked other than "natural", or itsms 23a or 28a-f show or other traumatic event. It a Modical Examinat must be notified at	by Funeral Director	10e. Street and Number 5007 Huron Street 11. Marital Status 12. Was Deccard Armed Formation of the status of t	edent Ever in U.S. 13. rces?	10f. Zip Code 20740 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		Liber 14. Race - Ar Black, WI Specify: E	ia merican Indian, hite, etc.
an "nature Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	Sb. Kind of Busines	ss/Industry
evant, Ine	Be	12th grade 1+yr 17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	Hospt aiden Sumame)	ial
is marke aumatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	Nancy T ng Address (Street and Number or Ru		City or Town, State	, Zip Code)
ant: If itam z. ury or othar t		Simeon Smith-Cousin 20a. Method of Disposition X Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State 206. Place of Dispo	McDonough Roas sition (Name of matory or other place) morial Park 6/	Date 20	c. Location - City	Md 21
important: I any Injury o once.		21. Signator and Funeral Service Licensee	with Mi	2. Name and Address of Facility arch F/H West 300 Wabash Ave	. Baltim	ore. Md	
sician edical		resulting in death)	aused the death. Do not enter	er the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Betwee Onset and De
miner							1
sician and burial-transit	sai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):				
attending I for use as	dicai	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C Due to d IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	(or as a consequence of): come of pregnancy inth 2 Fetal death 3 ant at time of death 5]Ectopic pregnancy □ Other (specify)		23d. Date of d Month	,
ed by the attending detached for use as	by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	come of pregnancy inth 2 Fetal death 3 ant at time of death 5 cown	Other (specify)		Month	Day Yea
ate has been signed by the attending I page 2 should be detached for use as	Physician/Medical	Cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	come of pregnancy inth 2 Fetal death 3 ant at time of death 5 cown	Other (specify)	1 ☐ Yes 24a. Was an autopsy performe	Month cco use contribute 2 PNo 3 1	Day Yea to the cause of deat Probably 4 □Unk autopsy findings ava o completion of caus
s certificate has been signed by the attending I lirector, page 2 should be detached for use as	To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	come of pregnancy inth 2 Fetal death 3 and at time of death 5 own	Other (specify) nderlying cause given in Part I. 26. Place of Dea	1 ☐ Yes 24a. Was an autopsy performe	Month 2 PNo 3 1 24b. Were prior to death 1 Ye 2 Other (Sp.	Day Year to the cause of dea Probably 4 □Unk autopsy findings ave completion of causes 2 No
ector: After this certificate has been signed by the attending toy the funeral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Medical	Cause. Enter Underlying Cause. Clisease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	come of pregnancy inth 2 Fetal death 3 ant at time of death 5 own	26. Place of Deant 3 DOA Other. 4 Nursing H	24a. Was an autopsy performe 1 Yes 2 (a. th (Check only one) ome 5 Residence 28d. Describe how	Month 2 In a 3 1 24b. Were prior to death 1 1 Ye 2 In a 1 1 Ye 2 In a 1 1 Ye 2 In a 1 Number or I	Day Year to the cause of deal Probably 4 □Unk autopsy findings avao completion of causes 2 No
s certificate has been signed by the attending I lirector, page 2 should be detached for use as	To Be Completed by Physician/Medical	Cause. Enter Underlying Cause. Clisease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	come of pregnancy inth 2 Fetal death 3 ant at time of death 5 with at the pown seath but not resulting in the unated by the payment of Injury and Injury a	26. Place of Deant 3 DOA Other. 4 Nursing H	24a. Was an autopsy performe 1 Yes 2 (autopsy performe 1 Yes 2 (autopsy performe 28d. Describe how 28d. Describe how 28f. Location (Stree City or Town, 5	Month 2 No 3 1 24b. Were prior to death 1 Ye 2 Other (Sp. injury occurred	Day Yea to the cause of deat Probably 4 □Unki autopsy findings ava o completion of caus as 2 □No Decify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2005 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth Month **Physician** th 6:30 Am June 18 2005 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Brightwood wherville maltimore (senesis If Under 24 Hrs. 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□M 2√F Yrs. Director 214-22-2125 NC 08-1906 Usuel Residence of Decedent permit. Pages 1 end 2 should be filled within 72 hours after death with the Marylend Deportment of Health end Mantel Hygiana. Important: If them 27 is marked other than "returnst," or frems 23a or 28a-f show any injury or other traumatic event. The Maryless! 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1**X** Xes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3918 Wasbash Ave 1A 21215 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 🎗 📆 No Specify: þ 3 Widowed 4 Divorced Black Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th grade na Domestic Worker Private 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stanley Smith Mine Chambers 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) Olivia V. Blount-Granddaughter 30 Mill Stone Road, Randallstown, Md Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 6/24/05 Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 23a. Part. Errief the disease, or compile to as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEMENTIA 4 cas Examiner Due to (or es a consequence of): Examiner LARGE HERNIA VENTRAZ attanding physicien end for use es the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes ZLNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No this After this funaral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completaly filled edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sporte MP 00053150 JUNE 1997 2005 M.D. 9650 SANTIAGO ROAD COWMBIA 11045 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) COUST A SHAWNNACA 31. Date filed (Month Dan Year) 8 2005 32 Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per doc 9844 6-28-05 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Rag. 2.005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 6 20^{Day} **Physician** 2005 Gills 12:29a M Judy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 103 Atholgate Lane Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1□ M 2XF 42 216-82-4011 Yrs. Director Md Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic evant, the Medical Examiner must be notified at X☐Yes 2☐No Director NA Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 1632 W. Lanvale Street Itams 23s Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2√2 No Specify: Specify: 3 ☐ Widowed 4 ♣ Divorced Black netural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Varies Housekeeping 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Carey Ballot Gills Cecil ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 of Health Lakesha Fulton Daughter 103 Atholgate Lane, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State οΞ 1

Burial 2 □ Cremation 3 □ Removal from State ö Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, Md. Mt. Zion Cem. 6-24-05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 aprulle 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** breas disease or condition resulting in death) reass /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 202 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) daughter's examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident 24 hours after deat Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 2

DHMH 17 Rev 1/2001

State Registrar 150 MD

838

ompleted cause of death (Item 23a) (Type, Print)

Hospice

D24170

· Eutaw St. Baltimore,

			1 - State of Maryland / Dep	artment of Health and Nertificate of Death		2005 2	1256
	Physici		Decedent's Name (First, Middle, Last) James Marcus Grim	es	2. Date of Death Month June	Day Year	Time of Death 1:30 a. M
)	/Medic Examir		4a. Facility Name (If not institution, give street and number) 5409 Trotter Rd	4b. City, Town, or Location of Death		4c. County of Death	d
	Funeral Director		5. Social Security Number 218-68-1150 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y		(State or Foreign
	e Maryland 8s-f show	Director	10a. State 10b. County 10c. City, Town or the Maryland Howard	ocation Clarksville		1	nside City Limits
	th with the 23a or 2	al Dire	10e. Street and Number 5409 Trotter Rd.	10f. Zip Code 21029	10g	Citizen of What Country?	
980	hin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Evantiac (rust be inclifted at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American In Black, White, etc. Specify: Wh	
21215-0036	within 72 sne. than "nai	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Physicians Assistan	king	b. Kind of Business/Industry Healthcal	
	ba filed Ital Hyg Id otha evant,	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	iden Sumame) lizabeth Kalb	
Maryland	2 shou and N is man	To		ling Address (Street and Number or Ru	ral Route Number, C	City or Town, State, Zip Code	3)
Baltimore, 1	Heal Heal tam 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	ematory or other place)		1029 c. Location - City or Town, S Clarksville, I	
Baltin	permit. Pages Department of important: If if any Injury or once.		21. \$ halue of Funeral 16 you Licenses Bright	22. Name and Address of Facility Slack Funeral Hom 3871 Old Columbia	e, P.A. Pike Ellicott 0	City, MD-21043	
V	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not expect the shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nter the mode of dying, such as cardiac		Inter	roximate roximate val Between et and Death
P.O. Box 68760,	at the death certificate be executed by the attending physician and nached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
Ś	quires tha n signed ald be de	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cau 2 No 3 Probably	
I Record	ian: The law requires that the rificate has been signed by th tor, page 2 should be detache	Completed			24a. Was an autopsy performe	24b. Were autopsy fin prior to complete death?	ion of cause of
sion of Vital	or Attanding Phyaician: after death. Director: After this certific in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? Yes 2 No	ent 3 DOA Other: 4 Nursing H	ome 5 esidence 28d. Describe how	ce 6 Other (Specify)	
Division	al or Att	Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Rou State)	te Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea manner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the causered at the time, date	se(s) and manner as stated. and place, and due to the o	cause(s)
)	within To the To the Comp	M	29b. Signature and title of certifier p ky	29c. License number	69	Date signed (Month, Day,	105 21228
	3		30. Name Ind address of Joson who ampleted cause of death (fem 23a) (fypological fem 23b) (figure 1)	5 16 W. B	(lin ha)	Buff ha	HIMS
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 8 2005	will the	0	. * - (

Physicia	ın	Decedent's Name (First, Middle	e, Last)						2. Date of De. Month JUNE		Year	3. Time of Death
/Medic	al	Sherry 2 4a. Facility Name (If not institution	A. Garey-W		4. 50				JUNE	21, 20		1640 P M
Examin	er	7 KILMORY COUR)	PERR		r Location of LL	Death			ty of Death IMORE	
Funeral Director		5. Social Security Number 212-56-5141	6. Sex 7. A	ge (In yrs. last birtho 56 Yrs	Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birt (Month, Da Dec 21	h y, Year)	9. Birth	place (State or Foreign introduction: ThCarolin
<u> </u>		Usual Residence of Decedent							Dec 21	, 1940	1101	
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene 11 then "naturel", or Items 23a or 28a-f show ent, Ite Medical Exam at must be modified at	ō	MD Balt	timore	10c. City, Town o	rLocation Le Riv	er						10d. Inside City Limits 1 ☐ Yes 2 X No
17.28a-1	rect	10e. Street and Number			10f. Zip	Code				10g. Citizen of	What Cou	
23a o	al D	38 G. Cool	Breeze D	rive		2	1220			USA		,
Item 27 is marked other then "naturel", or items 23a or 28a-f show other treumstic event, I'lle Medical Examination in its Learning at	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces ied 1 ☐ Yes 2 🕅	Ever in U.S.	13. Was Dece If Yes, spe	dent of Hi cify Cuba	lispanic Origi an, Mexican,	n? (Spe Puerto F	cify Yes or No- Rican, etc.)	- 14. Ra Bl	ice - Amer ack, White	ican Indian, , etc.
el', or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes Give	No	1 ☐ Yes	2 X No	Specify:			Spec	ity: Wh	ite
"natur	Completed	15. Deceden (Specify only higher	t's Education st grade completed)	16a. De	ecedent's Usu Give kind of wo fe. DO NOT u	al Occupa	ation during most of	of working	ng	16b. Kind of I	Business/li	ndustry
the Mark	dwo	Elementary/Secondary (0-12)	College (1-4or	5+)	Disab					n/a		
other	BeC	17. Father's Name (First, Middle,	Last)							Maiden Suma	me)	
natic e	户	Richmond H							Brow			
27 is marked of treumatic eve	1	19a. Informant's Name/Relations Toni Schlough		r 196. M	lailing Address 2406 E	s (Street a Beav	and Number er Cr	or Rural OSS	ing Ro	or, City or Town	n, State, Zi gewo	od MD
I Item 27		20a. Method of Disposition	• • • • • • • • • • • • • • • • • • •	20b. Place of Di					ate	20c. Location		
lant: If		1 ☐ Burial 2 ☑ Cremation `4 ☐ Donation 5 ☐ Other (S	pecify)	Bayvie	ewCrem	ato	ry 6	/28	/05	Balti	more	MD
Department of Himportant: If Ite any injury or ot once.	IJ	21. Signature of Funeral Service	Licensee	. 01	22. Name ar							meofEssex
*		23a. Part1. Enter the disease, or shock, or heart failure. List	com lications that cause	d the death. Donot						timroe	MD	21221 Approximate
ysician i		Immediate Cause (Final disease or condition		clerotic								Interval Between Onset and Death
Medical caminer		resulting in death)	d	a consequence of):		· abet	didi b	LOCU	.bc			
	er	Sequentially list conditions, if any, leading to immediate	b	a consequence of):							-	
sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	6									
		resulting in death) Last	Due to (or as	a consequence of):								
s the b	dica		d									
attending pl	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		م التعديد					23d. D.	ate of deliv	ery
the atte	sicla	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 □ Pregnant a		3 ☐Ectopic po 5 ☐ Other (sp					М	onth	Day Year
an O	Phy	Part II. Other significant condition	ons contributing to death I	out not resulting in th	e underlyina a	ause dive	en in Part I.		23e. Did to	bacco use cor	ntribute to	he cause of death?
pe e	ed by								1 🗆 Y	4.0		bably 4 Unknown
as been si 2 should l	Completed								24a. Was autop		Were auto	opsy findings available ompletion of cause of
cate ha	Com								perfor	rmed?	death?	2 No
	Be c	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only o			COENTS
든 교	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpati 28a. Date of Inju (Month, Date	ury 28b. Tim		28c. Injury Work	4 🗀 Nurs	-		lence 6 XIOt now injury occu		y) SCENE
ctor: After y the funer	catlo	1 Natural 5 Pendin 2 Accident Investig	gation		М	101	Yes 2 □ No					
n by 1	Certification;	3 Suicide 6 Could determ	ined 286. Place of In	jury - At home, farm, tc. (Specify)	, street, factory	, office		2	8f. Location (S City or Tow	Street and Num m, State)	ber or Run	al Route Number,
		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledge, d	eath occurred	at the tim	ne, date and	place, a	nd due to the o	cause(s) and m	anner as s	stated.
y filled i	10	(Check only 2 Medical	Examiner: On the basis of and manner st	of examination and/o tated.	r investigation	, in my op	pinion, death	occurre	d at the time, o	date and place	, and due t	o the cause(s)
the Funerer L	ledica	one)	1									
To the Funerel Direc completely filled in by	Medical	29b. Signature and little of certific	du 1	1	290	. License				29d. Date sign		
within 24 hours after To the Funerel Direc completely filled in by	Medica	one)	And	fleath (Item 23a) (Tu		OCM	Æ			JUNE 2	22, 2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Day Mary Lee Gilbert 21 2005 1805 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carrol1 Carroll Hospital Center Westminster 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 218-44-8148 1 ☐ M 2 🖾 F Md Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, it a Medicul Ever in er marker rediffied at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Md Carrol1 Sykesville 1 ☐ Yes 2 📉 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 4640 Poole Road USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√□ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) home care hospice worker health care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Audrey Irene Phillips Joseph Carl Adams Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe F. Gilbert (spouse) 4640 Poole Rd., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 NOther (Specify) entombment Sacred Heart of Jesus 6-25-05 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obliterens Bronchiolits **Physician** (montes disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** COPP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Munknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Mo 24a. Was an certificate has autopsy performed 1 Yes 2 1 No Hospital or Attanding Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral C 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 52035 22 ell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner West minister BINO Avenue CHACICO 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 2 8 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0300M JUNE 24, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL Balto. City OF BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/26/1936 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) UKRAINE 1□M 2XF Days Hours 217-33-9115 Director 69 Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6938 BROOKMILL ROAD APT. 1-A 21215 UKRAINE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 Yes 2 No WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 Is markad other than "n Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ISRAFI SPIRT REIZA LIBERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at Important: If Itam 27 is any injury or other trauonce. NEKHEMIA GILLER / HUSBAND 6938 BROOKMILL ROAD APT. 1A-BALTIMORE, MD 21215 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BALTIMORE HEBREW 06/26/2005 ^ 4 □ Donation 5 □ Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. ,/Usua 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 5051 day disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attanding Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) the r use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 24 hours a a Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2

State
Registrar

30. Name and address of

31. Date filed (Month, Day, Year)

2 YOI WEST

m

person who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

no

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Belvedue Avenue

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 23, Lillian M. Griffith 2005 June 7:46 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millenium Nursing & Rehab. @ Marley Neck Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🔀 F 98 Director 213-30-0028 Oct. 6, 1906 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or leans 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2√☐ No Director Anne Arundel Glen Burnie 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 6528 Clear Drop Court, #102 21060 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. hther than "natural", or ite 1 ☐ Yes 21☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Viola (Unavailable) Charles Bange 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6528 Clear Drop Court, #102, Glen Burnie, MD 21060 Frances M. Gibson - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 6/27/05 Elkridge, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signature of Funeral Service Licens 7250 Washington Blvd., Elkridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner ng physician end as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760. Physiclan/Medical that initiated events resulting in death) Last use 23b. Did tobecco use contribute to the ceuse of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown signed by b pe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? page 2 s 1 Vue 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place Death Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manuer of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending after death. Director: Atl 1 ☐ Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D

completely filled Hospitai 29a. Certifier Destribying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and many or as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

use of death (Itom 23a) (Tope, Pr

29d. Date signed (Month, Day, Year)

				artment of Health and Mer		ne v•2005	21261
			Decedent's Name (First, Middle, Last)		Date of Death		3. Time of Death
	Physici		Jonathon Alexander Giardini		Month D	2005	7120 PM
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death	
			FRANKLIN SQUARE HOSDITAL	Rosedale		BALLI	NORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea	ar) Cor	nplace (State or Foreign
	Director		N/A XJM 2 F Yrs. Usual Residence of Decedent	1 23	June 09,	2005 Ma	rýland
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-	ith the Marylar or 28e-1 show	to	MD N/a Baltim	ore			1 ☐ Yes 2 ☐ No
4	r 28e	rec	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Co	untry?
8	death with the Maryland ms 23e or 28e-f show rmust be mailted at	a D	3323 Kentucky Avenue	21213		U.S.A.	
X	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Amer Black, White	
ARd	36 after	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes ANNO Specify:		Specify:	
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	t within iene.	mo	College (1-4or 5+) O College (1-4or 5+)	I/A		N/A	
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1	re, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 is marked other then "neturel", or Items 23e or 28e-f show other traumatic event, its Medical Examinational Les multifles at	20 8	, , , , , , , , , , , , , , , , , , , ,	ling Address (Street and Number or Rural R			1
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	Baltimo permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeyal Service Licensee	22. Name and Address of Facility Mil. 6415 Belair Road Ba.			
			23a. Part1. Enter the disease of complications that caused the death. Do not en shock, or heart failure ast only one cause on each line.			<i>J.</i>	Approximate Interval Between
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	P =	ner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
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	8760, ate be executed hysician and the burial-transit	Ě	resulting in death) Last Due to (or as a consequence of):				
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	that	by Physiclan/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
	ords,				1 🗌 Yes	2 No 3 □ Pro	obably 4 Unknown
	of Vital Records, P.O. Box 6i Physicien: The law requires that the death certific t this certificate has been signed by the attending p radiaction, page 2 should be detached for use as	Completed			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
	of Vital Re Physicien: The la r this certificate hav	Eo			performed? 1 X Yes 2 ☐ i	? death?	·
	ital	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)		
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	on of ding Phy. After thi funeral	on:	27. Manner of Death 1 Shatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	d. Describe how in	ijury occurred	
	Sion thend death tor: /	icat	2 Accident investigation 3 Suicide 6 Coulombed 28e. Place of Injury - At home, farm, s		f Location (Street	t and Number or Ru	ural Route Number
	Division of Vital Records, I or Attending Physicien: The law requires tafter death. Director: After this certificate has been signs tin by the funeral director, page 2 should be	Certification:	4 Homicide determined 200. Flace of Injury Actions, family, and building, etc. (Specify)	treet, factory, othor	City or Town, St.		
	Division or To the Hospital or Attending Pleating 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	-	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or				
	the Ho lin 24 the Fu	ledica	one) and manner stated.				
	To T To 1	Σ	29b. Signature and title of certifier	29c. License number	290. [Date signed (Monti	, Day, rear)
			1 Cay Max UNIS	7 214724		6/15/0	5
			30. Name and address of person who completed cause of death (Item 23a) (Typi	1) A Common An R	ITime	n= 11.1	21237
	C	ate	DR KAY MONA WRIGH 1000 RAWK 31. Date filed (Month, Day, Year) 1. Registrar's Signature	I'N SqUARE DR. B.	AIII INOK	1010	01201
	Regist		JUN 2 8 2005				

Sharon R. Hall 05-3755 AKG

3100		State of Maryland / Department of b			_	
	1	State of Maryland / Department of the State of Maryland / Department of the State of Maryland / Department of the State of Registrar		Reg.	2005	2 262 3. Time of Death
Physicia	n	1. Decedent's Name (First, Middle, Last) SHARON R. HALL		Month	Day Year 005	
/Medica	r	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, C	or Location of Death		4c. County of Dea	ath
Funeral		Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		Date of Birth		inthplace (State or Foreign
Funeral Director		219 98 1148 1 A 20 F 39 Yrs. Months Days	Hours Min.	Date of Birth Month, Day Ye	1965	MARYLAND
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Baltimore, Maryland 21215-0036 permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Exercipational be notified at once.		10e. Street and Number 804 WALDORF AVENUE	21215	10g.	Citizen of What C	O A
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21215-0036 ad within 72 hours aff gjene. ar than "natural", or in Medical Exern.		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done	during most of working	16t	. Kind of Busines	s/Industry
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Maryland d 2 should be file th and Mental Hy ty is marked oth traumatic event	ို	19a. Informant's Name/Relationship (Type, Print) FRIEND 19b. Mailing Address (Stree				Zip Code) 21215
Ma and 2 s allth an 27 is ar trau		MILTON JUAN DUNSTON EL 2804 WALDO				ARYLAND
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Baltimore, bermit. Pages 1 ar Department of Hea mportant: if item any Injury or otha	I	'4 □ Donation 5 □ Other (Specify) METRO CREMATOR 21. Signature of theral Service Licensed	Y 6/6/0 ress of Facility GWYNN FU	-		LLE, MARYLA
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		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.		espiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) A. Hypertensive Cardiovascu Due to (or as a consequence of):	Lar Disease			
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of Vita Physician: this certific	L _o	Yes 2 No Pospital: 1 Inpatient 2€ER/Outpatient 3 DOA	Other: 4 Nursing Home	5 Residence		pecify)
ion of nding Phy th. :: After thi	atlon	1. Watural 5 □ Pending (Month, Day Year) Injury W	ork? □ Yes 2 □ No			
Division of Vital Records, for Attending Physician: The law requires the after death. Director: After this certilicate has been signed in by the funeral director, page 2 should be come.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	е 28	f. Location (Stree City or Town,		Rural Route Number,
Division of To the Hospital or Attanding Playin 24 hours after death. To the Funeral Director: After the completely filled in by the funera	al Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	time, date and place, an	d due to the cau	se(s) and manner	as stated.
tha Ho nin 24 h the Fu npletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	y opinion, death occurred		Date signed (Mo	
To To con	~	230. Signature and this or corning.	ME		ine 1, 20	
_	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Pe	nn Street	Baltimor	re. Marvi	land 21201
Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Registr		31. Date filed (Month, Day, Year) JUN 2 8 2005 JUN 2 8 2005				

Gerrod Hamlett 05-04296 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item. 1 per meg 2845.7-1-05 yttacith and Mental Hygiene

		1. Decedent's Name (First, Middle,	Lacti	-		rtificate of	Doutin	2. Date of D	Reg. No.	2005	21.26
Physician	_							Month	Day 25	Year	3. Time or or
/Medica	_	Gerrod Haml- 4a. Facility Name (If not institution,	ett Jer	rod Re	eginald	Lee Ham	Lett r Location of Dea	June		200 County of Dea	
Examine	ľ		give street and num	Delly		Baltimo		01	40.	N/A	
		Sinai Hospital 5. Social Security Number	6. Sex 7	' Age (In vrs	. last birthday)		If Under 24 Hrs	8. Date of Bi	dh		
Funeral Director		214-02-1309 Usual Residence of Decedent	1 ∑ M 2□F	22	Yrs.	Months Days	Hours Min		ay, Year) /1982	Ma	rthplace (State or Fore Country) ryland
M ==		10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City Lin
불혈 5	5	dom: land			D = 14						1 X Yes 2 □
pe notified	2	Maryland 10e. Street and Number			Dali	10f. Zip Code			10g. Citiz	zen of What C	ountry?
a e	5	3017 Wylie Aven	110			2121	5		-	S.A.	,
ms 2	2	11. Marital Status	12. Was Deced		J.S. 13.	Was Decedent of H		Specify Yes or N		14. Race - Am	erican Indian,
tal hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evaninar must be notified at Re Commissed by Fineral Director	n L	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	2 [XNo		If Yes, specify Cuba 1 ☐ Yes 2 💢 No	Specify:	rto Rican, etc.)	1	Black, Whi	
cal E	2	15. Decedent's			16a. Dece	dent's Usual Occup	ation		16b. Kir	nd of Business	s/Industry
ygiene. "natural", o verthan "natural", o t, the Medical Exan	2 -	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo d)	orking			-
The Party	5	11	College (1-	.3. 3+)	Un	employed			N	lone	
h and Mental Hygiene. 7 is marked other than ". Iraumatic event, the Mac		17. Father's Name (First, Middle, L	ast)				18. Mother's Na	me (First, Middle			
Menta arked atic ev	2	Reginald Mick	ens				Julis H	lamlett			
Department of Health and Menta Important: if itam 27 is marked any injury or other traumatic a gnce.		19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Maili	ing Address (Street	and Number or R	ural Route Numb	per, City or	Town, State,	Zip Code)
27 ls		Julis Hamlett /	Mother		3017	Wylie Ave	enue. Rai	ltimore	Mart	land 2	1215
tam othe		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place		Date		cation - City or	
y or	1	1 ∰ Burial 2 ☐ Cremation : 1 ☐ Donation 5 ☐ Other (Sp		- 1	•	,	07/	02/2005	Land	ledormo	, Marylan
ortan injur	1	21. Signature of Funeral Service L		Mţ	. Zion	Cemetery 2. Name and Address					
lmpo any ir	1	11				11 D. 1 ***	The	Derric	к С.	Jones	F/H, P.A.
	-	23a. Part1. Enter the disease, or c	complication that on	used the don	th Donot est	ar the mode of their	igts. Ave	Balt	1more	, Mary	land 2121
		shock, or heart failure. List o	only one cause on ea	ch line.				o or respiratory a			Interval Between Onset and Deatl
ysician	Ì	Immediate Cause (Final disease or condition resulting in death)	_a. Mu	utipl	1 900	ashot w	sounds				1
/ledical		rosaning in dealin)	_								
aminer		1	Due to (o	rasachise	quence 📆						
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 7:35 AM 25 200,5 /Medical Alvera M. Hewitt 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARTORO (INERSIDE DRIPN 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🖵 F Months Days Hours 90 Director 219-44-5690 Usual Residence of Decedent March 6, 1915 Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits avant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Harford Fallston 28a-f Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9 or Items 23a Funerai 1809 Laurel Brook Rd 21047 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Maryland 21215-0036 1□Yes 2□No Specify: þ Specify: White 3 ♥ Widowed 4 Divorced 'natural', Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ္ပ George Wessel Louisa Bender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Itam 27 \$20 W. Ring Factory Rd., Joppa, Md. Ruth Rennie/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date tX Burial 2 ☐ Cremation 3 ☐ Removal from State ō injury 4 □ Donation 5 □ Other (Specify) Most Holy Redeemer Cem. 6/28/05 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any ir Schimunek Funeral Homes 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician nyocardo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lere 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 8 Registrar

ORIGINAL

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	Physici /Medi	cal	Decedent's Name (First, Middle, L Cutherine A. Facility Name (If not institution, g.				4b. City, To		SKIN		2. Date of De Month June	24	Year 2005	3. Time of Death
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	Funeral Director			1□ M 2\\ F	89	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 6-30	y, Year) -15	Countr	Ga.
	a-f show	ctor	Md. 10b. County NA		10c. Ci	ty, Town or Lo Balti							10	d. Inside City Limits Y Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 1217 N. Bond St	reet			10f. Zip C	ode 121	3			10g. Citizen	of What Countr USA	y?
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, tre Medical Eventinal to neillied all once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Deceder If Yes, specify 1 ☐ Yes 2X		panic Ori , Mexicar Specify:		ecify Yes or No Rican, etc.)		Race - America Black, White, et cify: Blac	tc.
21215-0036	i within 72 h jiene. r than "natu	Completed	15. Decedent's & (Specify only highest g Elementary/Secondary (0-12) 8th grade	Education ra <i>de completed)</i> College (1-4or	5+)	(Give	dent's Usual (kind of work DO NOT use tion S	done du retired)	uring mos				f Business/Indu	ustry
Maryland ?	2 should be filed within and Mental Hygiene. Is marked othar than aumatic evant, the Me	To Be C	17. Father's Name (First, Middle, Las	t)	I	Parks			18. Mothe	∍r's Name	(First, Middle, Addie			nkn
	and 2 sho salth and i n 27 is me		19a. Informant's Name/Relationship Rodney Cole	(Type, Print) Nephew		286	3 Sea	mon			Altimor		vn, State, Zip C 21225	·
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If itam 27 any injury or othar tr. once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Special Content of the Co			Place of Dispo cemetery, crer Md. Nat	natory`or othe	er place		6 – 29-		Laure	n - City or Tow	n, State
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Lice Bloom B	gomson			Name and March	F.H	. Ea	st	1101		, Md. th Ave.	21202
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	a. Smal	a consec	vei ne quence of): /ei vo	crosis	of dying.	, such as	cardiac c	rrespiratory a	rrest,	1	Approximate niterval Between Disset and Death 12 hours
O. Box 68760,	ne death certificate be executed the attending physician and thed for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	of pregna	ancy	Ectopic preg						Date of delivery Month D	/ Vay Year
α.	The law requires that the death ite has been signed by the atten bage 2 should be detached for u	by	Part II. Other significant conditions	contributing to death I	out not res	sulting in the u	nderlying cau	se giver	n in Part I.		_	obacco use co		cause of death?
al Records,		Completed										an 24 bsy rmed? 2 No	prior to comp death?	sy findings available of cause of
of Vital	8 5	: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 🗷 Inpati		ER/Outpatier		Other	- 4 □ Nu	rsing Hor	(Check only one 5 Resident Res	dence 6 🗆 0		
Division	e Hospital or Attanding Phy 24 hours after death. Funeral Diractor: After thi etely filled in by the funeral or	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determine	De Dian of la	jury - At h	Injury ome, farm, str	М		es 2 🗆	No _	28f. Location (S City or Tov	Street and Nu		Route Number,
	To the Hospital or Attank within 24 hours after deatl To tha Funeral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis of and manner si	of examina	owledge, death ation and/or in	n occurred at vestigation, in	the time my opi	, date an nion, dea	d place, a	and due to the ed at the time,	cause(s) and date and plac	manner as stat e, and due to t	ed. he cause(s)
\$11	To the vithin 2 To tha complete	Me	29b. Signature and title of certifier Cymu & 30. Name and of dress of person who	Sihe, M	> death (Iter		Print)	ZE 5	number			June		2005
4	Sta Registi	-	Jayme E. Loca 31. Date filed (Month, Day, Year) JUN 2 8 20					e s	treet	· Bi	Himor	e, MD	2128	7-9106

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 27, 2005 **Physician** Marvin F. Hilling рм 8:24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Edgemere 9324 Sea Point Rd. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1⊠M 2□F 214-38-4651 Yrs. Director 66 WV May 20,1939 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow r than "natural, or Items 23a or 28e-1 show the Mcdical Examiner must be notified at MD. Baltimore Edgemere 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 9324 Sea Point Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Lever Brothers 12 years Defi Operator _years permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If Item 27 is marked othr any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oris Barnett Mora Robey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Hilling wife 9324 Sea Point Road, Edgemere, MD. 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory July 1,2005 Baltimore City, MD. ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each int. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition yeurs **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence oi). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Year Dav 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 25/40 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 5 autopsy performed? certificate 1 ☐ Yes Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Sin funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending Injury 1 🗌 Yes 2 🗆 No death, 2 Accident investigation after death the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8114 SANDPIDER CIRCLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 2 8 2005

		-	For State Registrar	State of Mary	•	artment of H tificate of L			iene ••• •2 0 0 5	21267
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	h Day Yee	3. Time of Death
	Physicia /Medic		Leona Josephin	e Hood					23 200	5 3 30 PM
	Examin		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
		١.	St. Agnes Ho	spital		Baltin	1056		N/A	
	Funeral	- 1	5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	irthplace (State or Foreign Country)
	Director	ļ.,	217-10-7400	□M 2 X IF	80 Yrs.			Dec 28	, 1924 M	aryland
	and *	}	Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ecation				10d. Inside City Limits
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	leath	era	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Race - Ar	nerican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural, or items 23a or 28e-1 show amy injury or other traumatic event, the Modical Exercitive must be multified at annex.	by Funeral	1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	İ	lf Yes, specify Cuba 1 ☐ Yes 2 💢 No	n, Mexican, Puerti Specify:	Rican, etc.)	Specify: W	
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<u> a</u>	uld b Ments vrked trice	70	Leon Joseph Luk	as			Rosa	lie Ziol	kowski	
Maryland	2 sho and l is ma		19a. Informant's Name/Relationship	**	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Number,	, City or Town, State	, Zip Code)
Σ.	and and in 27		Paul D. Hood, Jr						e, Maryla	
ore	of He		20a. Method of Disposition 1 Burial 2 Tremation 3 [Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	9)		20c. Location - City	or Town, State
altimore,	Pag ment ant: i		4 □ Donation 5 □ Other (Speci	(y)	Metro Cr	ematory I	nc. 06/2	3/05		e, Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Seaving Los Thomas Gregor	nsee	22	2. Name and Addres Cremation 299 Frede	s of Facility Society rick Roa	Of Mary d Baltim	land Inc. ore. Marv	land 21228
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that coused the	death. Do not en	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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Вох	it the death certific by the attending p tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	the de	/sic	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4□Pregnant at tim 9□Unknown	e of death 5 [Other (specify)				
Ρ.	that the	Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	bacco use contribute	to the cause of death?
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Vital	Physicien: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	• C C C C C C C C C C C C C C C C C C C	oth Oth	ne:	th (Check only on		
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	To the Hospitei or within 24 hours after To the Funeral Direction Completely filled in b	edical C		hysician: To the best of number: On the basis of examiner: and manner stated	amination and/or in					
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)	->		>ttu-	~5	710	Coo	0000		0/22/05	
	14		30. Name and address of person who 900 CA+on 31. Date filed (Month, Day, Year)	completed cause of deat	h (Item 23a) (Type	Print) ET	ENNE	Naovi	Mana.	-MD
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature		xia of			
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Hood, LeonA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** 129501 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Colvins19 Nousin HOL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours MAR 26, South Africa 108-54-6043 94 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Howard Funeral Director Columbia or items 23a or 28a-f 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 10460 Owen Brown Road 21044 Switzerland 11 Maritel Status 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 21 No If Yes, Give 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0020 Specify: Completed by 3√2 Widowed 4 Divorced Year or Dates "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. 6 Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith end Mentel h Be John Edward Lowden Maria Josefa Urondo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Depertment of Health e Important: if item 27 is any Injury or other trace Federico E. Heinz/son 10460 Owen Brown Road Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/28/05 Baltimore, MD 22. Name and Address of Fedility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licens Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of): Part fl. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 000 C47 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 27 No 1 ☐ Yes 2 ☐ No 1 _ Yes eral Director: After this certificatilled in by the funeral director. 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a

To the Funeral D

completely filled to certifying Physicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) OL 31. Dete filed (Month, D 32. Redistrer's Signeture State Registrar

	_		1 - For State Registrar	State of M	Marylan		rtment <i>tificate</i>				_	-	e 200	5	21269	
	Physici	an	Decedent's Name (First, Middle, L.								2. Date of De. Month		ay	Year	3. Time of Death	_
	/Medic	al	Deanna I. 4a. Facility Name (If not institution, g	Harris			4. 05. 7		1		June	2		2005	4:45 P M	_
	Examin	er	Union Memorial		r)				Location of .more	of Death		44	c. County o	A A		
	Funeral Director		5. Social Security Number 6. 220–34–5694	Sex 7.7 1 ☐ M 2 ☑ F	Age (In yrs. I	ast birthday) Yrs.	If Under	1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da Oct. 3	y, Year	938	Coun	ace (State or Foreigr try) y land	7
	ט		Usual Residence of Decedent								oct. 5	, I.		1 ICI I	yland	_
	show	'n	Maryland N/A			,Town or Lo altimo								11	Od. Inside City Limits XXYes 2 □ No	
	286-f	recto	10e. Street and Number				10f. Zip	Code				10a C	itizen of W	hat Coun		_
	th with	Funeral Director	3939 Roland Aven	ue ç 711					211			-	JSA	nat oban	.,.	
	tems termination	uner	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13. \	Vas Decede Yes, speci	ent of Hi	spanic Ori n, Mexicar	gin? (Spec	cify Yes or No Rican, etc.)	-	14. Race Black	- Americ		
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any njury or other treumetic event. The Medical Evarth at must be notified at page.	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 € If Yes, Give Year or Dates			I□Yes 2		Specity:				Specify:		ite	
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ılan	uld be Jental rked c	To Be	Emerson Russel	1 Garrison	1					Irma	Sulli			•		
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship								Route Number	-			,	
	1 and Health tem 27		Kathryn Duman 20a. Method of Disposition	Friend	20b. P	lace of Dispo	sition (Nam	e of	1		910 Ba.		nore,			
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Baltimore,	permit. Departminimporte		21. Signature of uneral Service Lis	ense		22	. Name and	Addres	s of Facilit	ty				_		
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final						g, such as	cardiac or	respiratory as	rest,			Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	aHSCEN	as a consequ	Chol	angi	112							3weeks	>
	Examiner		Sequentially list conditions.	Seps	is										2 weeks	i.
V	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to [or a	as a cons⊸u	ience af):										
o	execu in and rial-trai	Examin	that initiated events resulting in death) Last	C. Due to (or a	as a consequ	uence of):										_
8760,	icate be executed physician and s the burial-transit	dical		d												
9		0	IF FEMALE:	23c. If yes, outcon	ne of pregna	ncv					-					-
. Box	that the death certifi ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 □Live birth 4 □ Pregnant	2 Fetal at time of de	death 3[Ectopic pre Other (spe						23d. Date Mont		ny Day Year	
P.O.	at the d by th etache	Phys	9 🗆 Unknown	9□ Unknown				_								
	es be	by	Part II. Other significant conditions	contributing to death	but not resu	atting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to		*		e cause of death?	
Vital Records,	law requir as been si 2 should	Completed									24a. Was		24b. W	ere autop	sy findings available	_
E E		Com									autop perfo 1 ☐ Yes	rmed? 2 2 No	de	eath?	npletion of cause of	
Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 🛶				Otho	The same of the		Check on o					
of		n: To	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of Ir	njury	ER/Outpatien 28b. Time of		Bc. Injury	at Nu		e 5 🗌 Resid 8d. Describe h)	-
ion	Attending death. ctor: Afte y the fun	atlo	1 Natural 5 ☐ Pending investigat		Day Year)	Injury	М	Work 1 □ \	? ′es 2 🔲 I	No						
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 289. Place of	njury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory,	office		2	Bf. Location (S City or Tow			r or Rural	Route Number,	
	spitel lours a nerel I		29a. Certifying	Physicien: To the be	st of my know	wledge, death	occurred a	it the tim	e. date an	d place, ar	nd due to the	cause(s	s) and man	ner as sta	ated.	
	he Ho in 24 h he Ful pletely	edical	(Check only 2 Medical Ex	eminer: On the basis and manner	of examinat	ion and/or inv	estigation,	in my op	inion, dea	th occurre	d at the time, o	date an	nd place, an	nd due to	the cause(s)	
	with To t	Σ	29b. Signature and title of certifier	0					number	0.11			ate signed			
	0		20 Name and address of access	o completed	f dooth /ft-	220) (T	Drimt)								3 2005	_
	8		30. Name and address of person who Chanda Be	11 MP	Jeath (Item	Aion	Mem	ori	aQ :	Hosn	ital	Ba	Him	ore.	MD	
1.0	Sta	-	31. Date filed (Month, Day, Year) JUN 2 8 201	32. Regis	strar's Signat	ture	w _	-						-1-)		_
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Charlotte Mae 3:30 P. M 2005 Happel June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1605 Tieman Drive Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Y. Nov. 20, 5. Social Security Number 220 01 4120 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Year) 1919 1 □ M 2 ☐ ¥F 85 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Glen Burnie Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with U.S. 1605 Tieman Drive 21061 or Itame 23a Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: Specify: 3 X Widowed 4 ☐ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within ?
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns eny injury or other treumatic average. Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Blanche Clarissa Mazingo John Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Antlitz / Daughter 1605 Tieman Drive Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6/25/2005 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 nomento 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) teasi **Physician** Congestice /Médical **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): sician a Division of Vital Records, P.O. Box 68760, the attending phy: IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months Month 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3FT DOA 28c. Injury at Work? 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 | Pendina М death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 □ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Retthine SRIDHAR. ATIUR 8109 31. Date filed (Month, Day, 2005 32. Registrar's Signatur Registrar

State of Maryland / Department of Health and Mental Hygieng For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20ď5 **Physician** June 10:45 A.M Eileen Marie Horn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death **Examiner** Chesapeake Hospice House Linthicum Anne Arundel 8. Date of Birth (Month, Day, Y Feb. 10 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 83 vrs **Funeral** Year) 1922 Min. Days Hours 1 □ M 2 X F Maryland 214 14 4136 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment: If lens 27 is marked other than "natural" any injury or other trainment. 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Maryland 1 ☐ Yes 2X No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 7863 Crilley Road 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) Salesperson Shoe Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Emil Koepf Hazel Sheckells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Carter / Daughter 8304 Sycamore Road Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 6/28/2005 Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Part1. Enter the disease, it of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ut to my one cause on each line. 23 . Part1. Enter the disease, Approximate Interval Between Onset and De Immediate Cause (Final disease or condition resulting in death) **Physician** Tatt /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 moo ō Year Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? ð 2 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has I page 2 2 2 No 1 ☐ Yes or Attending Physicien: funeral director, Be 25. Was case referred to medical HOSPICO 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Deatural 5 Pending 2 🗌 No death. investigation 1 Tyes 2 Accident within 24 hours after death To the Funerel Dirsctor: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Medical 29a, Certifie 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signate and title of certiler 7 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 861 te 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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	Physici /Medic		1. Decedent's Name (First, Mi		ARM.	SON						2. Date of De Month	ath Day	Year		Time of	Death 30fm
	Examin		4a. Fecility Name (If not institu 4906 Ten Mil	ls Ro	ad			Cc	olumk				F	County of De			
	Funeral Director		5. Social Security Number 251-60-0102 Usual Residence of Decedent	6. Sex	M 2□F 7.	Age (In yrs 89	: last birthday) Yrs.	Months	Days	If Under: Hours	Min.	8. Date of Bir (Month, Da AUG • 28	v, Year)	9. B So			or Foreign olina_
	hours after death with the Maryland lural', or Itema 23a or 28a-f show al Ezatra normal be notified at	ctor	10a. State 10b. Cou	-			ity, Town or Lo lumbia	ocation									ity Limits 2 X No
	with the	Director	10e. Street and Number					10f. Zip						en of What (Country?		
	er death v	Funerai	8047 Brookmo	1	2. Was Decede Armed Force	s?	J.S. 13.		203 lent of Hi offy Cuba	spanic Orig	gin? (Spe i, Puerto	acify Yes or No Rican, etc.)		JSA 4. Race - An Black, Wh		ndian,	
0036	hours afte tural', or I	þ	1 Never Married 2 Nover Marrie	ed	1 Tes 2 If Yes, Give Year or Date	_	.,	1 Yes		Specify:				Specify: B			
Maryland 21215-0036	n 72	Completed	(Specify only his Elementary/Secondary (0-1		completed) College (1-4	or 5+)	(Give	dent's Usua kind of wor DO NOT us	rk done a se retired,	ation furing most)	t of worki	ing	Sout	d of Busines th Car te Hos	olin	a	
land 2	should be filed withind Mental Hygiene. marked other than timatic event, the Mental Me	To Be C	17. Father's Name (First, Midde Frank Harris									(First, Middle McDon	, Maiden S				
	and 2 shoul ealth and Me n 27 Is marl her traumati		19a. Informant's Name/Relati					Transition of the second				al Route Numb Olumbia	-	Town, State 2104	_	(e)	
Baltimore,	Pages 1 and 2 ent of Health nt: If item 27 I ry or other tre		20a. Method of Disposition 1 Burial 2 □ Cremati 4 □ Donation 5 □ Othe	n 3 □Re	emoval from Sta	ıte	Place of Disponentery, cre	matory or o	ther place			/2005		ation - City o			
Balti	permil. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Serv		ides	7	Wi	2. Name an Ltzke	d Addres Fune	s of Facilit	y Homes	s, Inc.			210		
	Fnysician /Medical Examiner		23a. Part1. Enter the disease shock, or head dilure. Immediate Cause (Final disease or condition resulting in death)	a a	Pu Due to (or	as a conse	ath. Do not en	ter the mod	e of dying	g, such as	cardiac (or respiratory a	rrest,		Inte	proximat irval Bet set and I	ween
68760,		Icai Examiner	Sequentially list conditions, if any, reading to him callate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	PNE	UM 3M	quence of): E CTO (quence of):		<i>P</i> (JC; (ak	INT) D(26	- AGE				
.O. Box 68	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	3c. If yes, outco 1 Live birtl 4 Pregnan 9 Unknow	n 2 ☐ Fet tat time of	al death 3	⊒Ectopic pr ⊒ Other (sp					23	3d. Date of d Month	elivery Day	À	Year
S, P	quires that in signed by all be deta	by	Part II. Other significant con	litions con	tributing to deal	h but not re	sulting in the u	underlying c	ause give	en in Part I.			obacco us Yes 2	e contribute	to the ca		leath? Jnknown
Il Record	: The law requires that the cate has been signed by th page 2 should be detache	Completed	<u> </u>									24a. Was auto perfo 1 Yes		24b. Were prior to death?	comple?	tion of c	available ause of
Division of Vital	il or Attending Physician: The after death. Director; After this certificated in by the funeral director, pag	Certification; To Be	3 ☐ Suicide 6 ☐ Co	Н	28a. Date of (Month,	njury Day Year)	28b. Time of Injury	of 2	8c. Injury Work	er: 4 🗆 Nu	rsing Ho	n (Check only of the control of the	dence 6 how injury			ute Num	House House
D	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in I		29a. Continer 12 Centi (Check only 2 ☐ Medi		ician. To the beer: On the basi	st of my kr	iowiedya, daa					and due to the	cause(s) a)
	To the l within 2. To the I complete	Medical	29b. Signature and title of cer	ifier	and manne	stated.		290	. License	number			29d. Date	signed (Mo	nth, Day,	Year)	
	¹		30. Name and address of per	on who con		of death (Ite	om 23a) (Type 52	Print)	OLPH	hN S	me	ET B	Ation.	me r	02	121	7
	Sta Regist		31. Date filed (Month, Day, Y	2 8 2	32. Rec	trar's Sign	nature	boots	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 04 PM **Physician** ONES OHNNIE 2005 UNE /Medical 4c. County of Death 4b. City, Town, or Location of Death Fecility Name (If not institution, give, street and number) **Examiner** TIMORE US PITTAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Days | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | M 9. Birthplace (State or Foreign Spuntry)

NAKYLAND 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 214.54.2121 Vrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours atler death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be multified at once. 1 Yes 2 □ No ATIMORE MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HAR FORD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 201 No Specify: þ 3 ☐ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BATIMORE / ABOKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental TREEMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Informant's Name/Relationship (Type, Print) PARKVILLE, MD 21234 MUEN (SISTER EWOOD 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date Cometery, crematory or other place)

CREEN MOUNT CREMATORY 6.28.05 BATIMORE, MAKYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Pacility CREMATION SERVICES 21. Signature of Funeral Service Licensee 15151 BATIMOKE NATIONAL PIKE BALD, MO 21229 10. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence f): **Physician** weeks disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualty for as a consequence off Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page. d 1 Yes 200 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\sum \) Nursing Home Certification: To 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier UNE 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIRORE, MD 21202 PIARE 0514 301 ST JUSTOH 31. Date filed (Month, 2007, Year 32. Resistrar's Signature State 2005 Registrar

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Patient known as Johnson, James.

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shou and M	umat	-	RICHARD JOHNSO 19a. Informant's Name/Relationship (1)	ype, Print)	19b. Mailin	g Address (Street		TURNER	er, City or Town, State,	Zip Code)
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Physicie r this cert		<u>د</u> ا	1 Yes 2 No 27. Manner of Death	1 Minpatient		3□ DOA Othe	4 Nursing Hon		ence 6 Other (Spe	cify)
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	w requires that been signed b should be deta	by	Part II. Other significant condition Hypertecuri	•	h but not resulting in	the underlying o	ause give	n in Part I.					ably 4 EUnknown
I Records,		Completed	Herath C Baleton							24a. Was an autopsy perform	.	prior to cor death?	psy findings available inpletion of cause of
of Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	m		heck only one			
of	Phys r this ral dii	To To	1 Yes 2 No 27. Manner of Death	28a. Date of (Month,			8c. Injury	at		5 Resider Describe hove			()
ion	Attending I ir death. ector: After by the funer	atlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year) In	jury M	Work	? ′es 2 □ N	0				
Division	in Sir e	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace 01	Injury - At home, fari , etc. <i>(Specify)</i>	m, street, factor	, office		281.	Location (Stre City or Town,		imber or Rura	l Route Number,
	Hospite 4 hours Funeral tely fille	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be kaminer: On the basi and manner	s of examination and	death occurred /or investigation	at the time, in my op	e, date and inion, death	place, and occurred	due to the cau at the time, da	use(s) and te and plac	manner as st	ated. the cause(s)
	To the within 2 to the comple	Σ	29b. Signature and title of certifier	7	(ئۇسىد	290	c. License	number		29	d. Date sig	ned (Month,	Day, Year)
•				2		1	196	67		(76,	(5 C)	
0	4 '	,	30. Name and address of person w		of death (Item 23a) (T	ype, Print)	Jus	7 45	38	jler Bo	may i	Marylon	751061
	Sta		31. Date filed (Month, Day, Year)	32. P eq	notice o orgination	- CI	7	, ,					
	Regist	rar	JUN 2 8	2005 1	K	Acarles							

			1 - For State Registrar	State of Man		epartment of F Certificate of I		ental Hygie	2005	21277	
	Physicia /Medic		Decedent's Name (First, Middle, Last,	D.		Johnson		2. Date of Death Month	Day Year 2605	3. Time of Death	
}	Examin Funeral Director		4a. Facility Name (If not institution, give STADNES H 5. Social Security Number 6. Security Number 10	EALTHO	ARE n yrs. last birtl	BALT	r Location of Death		4c. County of Death NA (ear) 9. Birthg County M	olace (State or Foreign ntry) Id .	
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town	or Location				10d. Inside City Limits	
	Many a-f sho	tor	Mđ.	NA	Bal	timore				1 X Yes 2 ☐ No	
	th with the 23a or 28a	al Direc	10e Street and Number 2631 Maisel Street	et		10f. Zip Code 21.	230	100	g. Citizen of What Cour USA	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinating any once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: B]		
21215-0036	within 72 ho iene. r than "natur tre Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation e completed) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aluminum Cutter			Bb. Kind of Business/In Kaiser Alum	·	
nd 2	al Hygi I othar vent, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name				
ylaı	2 should be and Mental Is marked of raumatic eve	To	Douglas		onroe		Mary		Johnson		
Maryland	id 2 sh Ith and 17 Is m traum		19a. Informant's Name/Relationship (T) Dorothy Johnson	_{/рө, Print)} Wife		Mailing Address (Street and Maisel			7-75-7	Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or othar tre		20a. Method of Disposition 1	Removal from State	20b. Place of cemetery	Disposition (Name of r, crematory or other place		ite 20	oc. Location - City or To		
Baltii	permit. F Departmo Importar any injur		21. Signature of Funeral Service Licens			22. Name and Addres			imore, Md. North Ave	21202	
68760,	ificate be executed Medical Applysician and Ap	edical Examiner		23a. Part1. Enter the disease, or comprishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence o	deriosclera n:	4			Approximate interval Between Onset and Death
P.O. Box 68	death certiff e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of delive	ery Day Year	
	The law requires that the tite has been signed by the hage 2 should be detache	ed by Ph	Part II. Other significant conditions co	ntributing to death but n			en in Part I.		cco use contribute to the		
Division of Vital Records,		Completed	·					24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of	
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	o Politica in	Oth	26. Place of Death				
ion of	Attending Physic death. actor: After this by the funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Out 28b. Ti	me of 28c. Injury Work	y at 28 k? Yes 2 No	e 5∐ Residen 3d. Describe how	ce 6 Other (Specificing injury occurred	ý)	
Divis	Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, far Specify)	m, street, factory, office	28	Bf. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,	
	To the Hospital within 24 hours a within 24 hours a Conpletely filled	Medical	(Check only 2 Medical Exami	sician: To the best of miner: On the basis of ex and manner stated	amination and	death occurred at the tin Vor investigation, in my o	pinion, death occurred	d at the time, date	e and place, and due to	o the cause(s)	
	To Troop	2	29b. Signature and title of certifier	2	111	29c. Licens			d. Date signed (Month,		
	, , [30. Name and address of person who co	ompleted cause of deat	h (Item 23a) (Type, Print)	075049	v	une 26	2005	
10	Sta Registr		Scott Berger 31. Date filed (Monty 10 N 12918 20	005 33 Angistrar's	nes	Hamital	900 Car	on Aver	rue Baltim	se Mary ling	

JOHNSON, EDWARD

			1 - For Stata Registrar	State of Maryland	I / Depa		ealth and M	lental Hygid	_	21278
	Physici		Decedent's Name (First, Middle LINDA		11150	N		2. Date of Death Month	Day Yeer Z 5 2005	3. Time of Death - 08: 50 M
	/Medi Examir		4e. Facility Name (If not institution				Location of Death	Juit	4c. County of Death	
			UNIVERSITY OF MAYLAND NETICA CENTER BALTIMOR 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un						N/A	
	Funeral Director		5. Social Security Number 215-70-6029 Usual Residence of Decedent	6. Sex 7. Age (In yrs. las	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)		place (State or Foreign intry)
	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28a-f show the Madical Eval in actinist by rigilitied at	ب	10a. State 10b. County		Town or Lo					10d. Inside City Limits
	the Ma 28a-f	by Funeral Director	10e. Street and Number	15a	15im	10f. Zip Code	-	100	g. Citizen of What Cou	1. Serves 2 □ No
	th with 23e or	al Di	507 Arche	r St.		212	30		4.5.1	4.
	er dea	uner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13.	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
036	er's aft	by F	1 X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 _ Yes 2 M No If Yes, Give Year or Dates:		Yes 27 No	Specify:		Specify: 13 la	ick
21215-0036	"netur	Completed	15. Decedent (Specify only highes		16a. Deced	lent's Usual Occupa kind of work done d OO NOT use retired)	ition furing most of worki	6b. Kind of Business/li	ndustry	
212	filed withir Hygiene. Ither then int, the M	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Food	Service	*	- (Cafeter	ia
	be filed ital Hygid of other event, t	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Name	(First, Middle, Ma	6	-
Maryland	2 should be and Mental is marked of sumetic eve	To	Lewis Ja 19a. Informant's Name/Relationsh	hn82~	19h Mailir		Annette	EIKI	City or Town, State, Zi	in Code)
	1 and 2 s Health an iem 27 is other treu		Quishia Bro	endford dauchter	507	Archer	- 1 7	Salto. U	d. 21230	
Baltimore,	of of the second		20a.Method of Disposition 1 ☐ Burial 2 M Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from State cen	ce of Dispo netery, cren LNMOU	sition (Name of patory or other place	,	Date 20	R. Location - City or T	own, State
altii	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service I	101~	C ²²	Name and Adding	s of acity	Funeral	Service F	A
	207 2 2		222 Batt Fator the disease of	complications that caused the death.	Do not ont	101 McCu	Mod St	Balf.	hd. 212	
4	Physician /Medical		shock, or heart failure. List a shock or heart failure. List a shock or condition resulting in death)	aSEPS (S		or the mode of dying	, such as cardiac c	r respiratory arres	l,	Approximate Interval Between Onset and Death
	ite be executed sysician and he burial-transit ne	icai Examiner	Sequentially list conditions, in any, hading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. VRE ENDO Due to (or as a conseque) c	CARD	21715				
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal di 4 Pregnant at time of deal 9 Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant condition HY7ER KALE	ns contributing to death but not resulti	ing in the ur	derlying cause give	n in Part I.	23e. Did tobad	cco use contribute to t	he cause of death?
Records,	The law requ	Completed	RENAL FAILU	re				24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death			
of	Phys rthis raldii	n: To	1 Yes 2 No 27. Manner of Death	Inpatient 2 LEF	VOutpatient 8b. Time of	3 ☐ DOA Other	4 Indianing Hor	ne 5 Residence 28d. Describe how	e 6 Other (Special injury occurred	(y)
sion	ottending f death. ctor: After y the funer	atio	1 Natural 5 Pending investig	ation	Injury		? es 2 □ No			
Division	i or Att after de Directe J in by t	Certification:	3 Suicide 6 Could n 4 Homicide determine		e, farm, stre	et, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
_	Hospita Hours Funerei Tely filled	edical Ce	29a. Certifier Check only one) Certifying	Physician: To the best of my knowle examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	and due to the caused at the time, date	se(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	1		29c. License			Date signed (Month,	
	6		Colm	GN, MD		1 1 7	164355	16701 1	UNE 25, 2	2005
J	17		30. Name and address of person v GRAHAM SHYDS	tho pleted cause of death (Item 2)	За) (Туре, Г	Print)				
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8	32 Registrar's Signatur	- Suc	le de la company				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:30 PM Louise Elizabeth Jones June 25, 2005 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6 Brooking Ct. #201 Timonium Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 579-10-1227 Yrs. July 23, Director 86 NC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28e-f ehow 10a. State 1 ☐ Yes 2X No Directo Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Iteme 23a or the Medical Exeminer must be 6 Brooking Ct. Unit 201 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 N/A Homemaker Own Home permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Importent: If item 27 is marked othe eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be James Newton Evans Ceclia Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Herbert B. Jones/Husband 6 Brooking Ct. #201 Timonium, MD 21093 20b. Place of Disposition (Name of cometery, crematory or other place)
Dulaney Valley
Memorial Gardens June 29. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Timonium, MD 21. Signature of Funeral Socior Licer see 22. Name and Address of Facility Lemmon Funeral Home of Dulanev Valley, 10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause [Disease of a jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown δ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown as been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed 1 Yes 2 No Be 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 | Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 0 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Jeffrey Alexander M.D. 120 Sister Pierre Dr. Suite 101 Towson, MD 21204 31. Date filed (Month, Day, Year) JUN 2 8 2005 32. Registrar's Signature State Registrar

		partment of Health and Mental Hy	/giene Reg. 2 005 21280
Dhysisian	Decedent's Name (First, Middle, Last)	2. Date of Do Month	eath 3. Time of Death
Physician /Medical	Elizabeth M. Johnson	Jun E	-21-2005 5 20 M
Examiner	4a Facility Name (If not institution, give street and number) Levindale Hebrew Geriatric Center and Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min (Month D	rth 9. Birthplace (State or Foreign ay, Year) Country)
Director	Usual Residence of Decedent		3, 1928 Maryland
yland	10a. State 10b. County 10c. City, Town o	Location	10d. Inside City Limits
e Mar la-f si	Maryland N/A Baltin	nore	1☐Yes 2☐No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show apping or other traumatic event, the Madical Examination be notified at once. To Be Completed by Funeral Director	10e. Street and Number 3939 Roland Avenue	10f. Zip Code 21211	10g. Citizen of What Country? USA
r dea	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or Not If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
036 urs affe	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give 3 😾 Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify hite
Maryland 21215-0036 d.2 should be filed within 72 hours alt the and Mental Hygiene. 77 Is marked other than "natural", or traumatic event, the Madical Event To Be Completed by F		cedent's Usual Occupation	16b. Kind of Business/Industry
21215-00 ed within 72 ho ygiene. Par than "naturu.", tre Madical Ed. Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working e. DO NOT use retired)	Insurance
21.9 ad wit and the sar the sa	12	Clerical Worker	Underwriter
ind be file d oth evant	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	· · · · · · · · · · · · · · · · · · ·
Yan ould I Men Men varke varke	Conrad Och	Katie L. Sulli	
Mar d 2 sh h and 7 Is m traum	19a. Informant's Name/Relationship (Type, Print) Ann Stone Daughter 4	ailing Address <i>(Street and Number or Rural Route Numb</i> 7 Open Gate Court Notting	er, City or Town, State, Zip Code) ham. MD 21236
1 and 1 and Health	20a. Method of Disposition 20b. Place of Dis	sposition (Name of Date	20c. Location - City or Town, State
nol not ages and of the strict	1 ☑ Burial ✓2 ☐ Cremation 3 ☐ Removal from State cemetery, of	rematory or other place)	Parkville, Maryland
Baltimore, sermit. Pages 1 at mportant of Hea mportant: if item my niury or other and in the and item.	21. Signature of Funeral Service Licensee		
Bal Bar Departiment Importantic	refin B. Heurs	22. Name and Address of Facility Burgee-Henss-Seitz Funera 3631 Falls Road, Baltimo	1 Home, Inc. 21211
3	23a. Part1. Enlet the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	ocas had in las	Onset and Death
/Medical Examiner	resulting in death) a. Due to (or as a consequence at).		2100
2	Sequentially list conditions. b. Oscinary	artery diska	~ 76man/L
executed in and in-transit	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		5/1
8760, cate be executed thysician and the burial-transit alloal Examila	that initiated events resulting in death) Last C. Due to (r as a consequence of):	non	16140,16
Fig. 20 Q	//		,
64 46 0 0	O.		VI 1822-201-191-101
P.O. Box 6i P.O. Box 6i at the death certific dby the attending p etached for use as:	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
P.O. B. that the death detached for Physicia	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	B⊟Ectopic pregnancy □ Other (specify)	Month Day Year
P.O. P.O. dat the etache	3 - OTIKITOWIT		
ds, P.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
of Vital Records, Physician: The law requirest this certificate has been signe rat director, page 2 should be e. TO Be Completed by		1 1	/es 2 No 3 Probably 4 Unknown
Rec ne law has b ge 2 s		24a. Was	prior to completion of cause of
Vital Frician: The certificate rector, pag			rmed? death? 2 No 1 Yes 2 No
f Vital Ryysician: The is certificate the director, page	25. Was case referred to medical examiner? 1 Tyes 2 No Hospital: 1 X patient 2 TER/Quitest	26. Place of Death (Check only o	
on of ding Physical distributions of the distribution of the distr	1 Yes 2 No 1	A Nursing Home 5 Hesio	dence 6 Other (Specify) now injury occurred
Vision (Attending F death. ctor: After y the funeri	1	/ Work? M 1 ☐ Yes 2 ☐ No	
Division (I or Attending F acter death. Director: After t in by the funeric ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (5	Street and Number or Rural Route Number,
Div ttal or A rs after al Dirac led in by		City or Ton	
Division of Vital Records, P.O. Box 6 To the Hospital or Attanding Physician: The law requires that the death certification after death. Within 24 hours after death. To the Funansal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use and Medical Certification; To Be Completed by Physician/Me	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cinvestigation, in my opinion, death occurred at the time, a	cause(s) and manner as stated. date and place, and due to the cause(s)
To the vithin Fo this comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Mujani M	1944817	June 22200 5
	30. Name and address of person who completed cause of death (Item 23a) (Typ	a, Print)	your and
	Sull legan 2430	o betweelere are	June 22:2005 Kulhmere 21:175
State Registrar	31. Date filed (Month, Day Year) 32 legis ar's Signature	partis	My 2127 5

Rufus Jefferson, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04258 State of Maryland / Department of Health and Mental Hygiene RPD Reg. No 2 0 0 5 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** Rufus Jefferson, Jr. 2005 0634 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Glen Burnie Anne Arundel North Arundel Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**∑**M 2□F Months Days Hours 56 Yrs 428-96-5125 Nov. 22,1948 MS Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or then "naturel", or Items 23e or 28e-f show the Wedical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 1515 Jupp Rd. 21060 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify:AfricanAmerican Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Government other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pearlie Jefferson Rufus Jefferson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Prathuang Jefferson/Wife 1515 Jupp Rd, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 29, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation_ 3 ☐ Removal from State ö Department of Importent: If any injury or once. ` 4 ☐Donation 5 ☐ Othe (Specify) Maryland Veterans Cem 2005 Crownsville, MD of Funeral Service Licens 22. Name and Address of Facility Singleton Funeral Home 21. Signaturi 1 Second Ave SW, Glen Burnie, MD 21061 401411 23a. Part1. Enter the diseas shock, or heart failure. bease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hupertensive atheroscientic Cardiovascular Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off. Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 IX Yes 2 □ No 24a. Was an autopsy performed? Yes 2 □ No To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1

Yes 2 □ No P 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural death. 1 🗌 Yes 2 No 2 Accident after death Director: 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State

Registrar

31. Date filed (Month, Day, Year) JUN 2 8 2005

ING

29b. Signature and title of certifier

m.D 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street

mid

29c. License number

OCME

29d. Date signed (Month, Day, Year)

June 24, 2005

Baltimore, Maryland 21201

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

31. Date filed (Month, Day, Year) JUN 2 8 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

Q41406

29d. Date signed (Month, Day, Year)

July 27th 2005

21204

			For	State of Ma	ryland / Dep			Mental Hy	/giene		
			State Registrar		Ce	rtificate of	Death		Reg. No.	05	21283
	Physici		1. Decodent's Name (First, Middle, La:		r Joh	nson		2. Date of Do Month June	Day	Year 2005	3. Time of Death 0220 M
	/Medic Examin		4a. Facility Name (If not Institution, give KCSWICK MW.	street and number)	Center		or Location of Death			nty of Death	
	Funeral Director		5. Social Security Number 6. S 080-05-0817	ex 7. Age	(In yrs. last birthday) 93 Yrs.	Months Days		8. Date of Bi (Month, D July 1	15,1911	Con	place (State or Foreign otry) ISylvania
	ow other		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	8a-1 sh	Funeral Director	Maryland n/a		Baltimor	-					Yes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen d		ntry?
	ns 23	eral	700 W. 40 th St	12. Was Decedent E	ever in U.S. 13.	Was Decedent of	Hispanic Origin? (S	pecify Yes or N	U.S	A. ace - Ameri	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural" or 28 or 28a-f show any injury or other traumatic event. If a Machael Examiner must be notified at once.	by Fun	1 Never Married 2 Married 3 TWidowed 4 Divorced	Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	0	If Yes, specify Cub 1 ☐ Yes 2X No	oan, Mexican, Puert	o Rican, etc.)	Spec	lack, White, cify: Wh	etc. nite
21215-0036	72 hou	Completed by	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occu	during most of wor	rking	16b. Kind of		
121	filed within Hygiene. other than and, if a Me.	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retire	ed)		Sout	ing Co	mnany
	be filed tal Hygi d other evant.	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Nar			ame)	
Maryland	nould be a Mental I	To	Clarence	T 0	Johnso		Frances			Wood	
Mai	and 2 sho salth and n 27 is mu		19a. Informant's Name/Relationship (Jennifer Hewat	Daughter		,	tand Number or Ru Valley I				· ·
ore,	es 1 a of Hea if itam or otha		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Disponentery, cre	osition (Name of omatory or other pla	ace)	Date	20c. Location	n - City or To	own, State
altimore,	permit. Pages 1 and 2 Department of Health Important: If itam 27 any injury or othar tru once.		4 ☐ Donation 5 ☐ Other (Specification of Euneral Service Lice)	y)		Lley Mem. (2. Name and Addr	idns. 6/30	0/05	Timon	Lum, Ma	ryland
Ba	permit. Departimports any inj		· Robert K	nak		Mitchell Mitchell	-Wiedefel York Road	ld F.H. 1 Baltin	Inc.	rvland	21212
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications is at laused one cause one cause one cause of each lin	the death. Do not en	ter the mode of dy	ing, such as cardiad	or respiratory	arrest,	, , , , , ,	Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	men tia						YCars
	Examiner		Commence that the time and distance	b Due to (or as a	a consequence of):						
	be isi	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):					-	
, L	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):	 					
8760,	cate be physicii the bu	dical		d							
Вох 6	n certifie anding puse as	a a	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		⊒Ectopic pregnand			23d. [Date of deliv	эгу
P.O. B	es that the death certific igned by the attending p be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown		Other (specify)	-y		h	Ao nth	Day Year
	The law requires that the death certifi tie has been signed by the attending page 2 should be detached for use as	ğ	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the a	underlying cause gr	iven in Part I.		tobacco use co Yes 2 □ No		he cause of death?
Records,	aw require s been si 2 should b	Completed						24a. Was		. Were auto	ppsy findings available mpletion of cause of
		Com						auto perf 1 ☐ Yes	ormed? 2.2 No	death?	2 No
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		-5 0:	26. Place of Dea				
of	g Phys er this eral di	n: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injur (Month, Day		nt 3L DOA	4 🔀 Nursing F	lome 5 Res 28d. Describe	how injury occ	_	ý)
sion	eath. or: Aft	catio	1 SNatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n		M 1]Yes 2 □No				
Division	s after d al Direct ad in by	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju building, etc	iry - At home, farm, st :. (Specify)	reet, factory, office		28f. Location City or To	(Street and Nur own, State)	nber or Run	al Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this of completely filled in by the funeral dire	edical (29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of niner: On the basis of and manner sta	examination and/or it	th occurred at the to	time, date and place opinion, death occu	a, and due to the urred at the time	cause(s) and o	manner as s e, and due t	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1 2			se number		29d. Date sign		
	^		1 Joson 186				61199		Jone	27,	2005
	9		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	M Charls	st, Suite	203 1	Baltimoi	c MD	21204
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 8 201	3 Registra	r's Signature	ails 1					

6/27/05 @ 2:20 AM

Johnson, Clarence

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		_		State of Maryland / Dep. 3a&27 per me G844-6	rtilicate of Death							
Physicia			1. Decedent's Name (First, Middle, Last)				Day Year					
	/Medic		4a. Facility Name (If not institution, give s	seph Krieger	4b. City, Town, or Location of Dea	June th	21 2005 1920 M 4c. County of Death					
	Examili	ei	4123 Falls Road		Baltimore		Baltimore City					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) M 2□ F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Ye	9. Birthplace (State or Foreign Country)					
	Director		215-78-8516 112 Usual Residence of Decedent	47 Yrs.		FEB 3, 1	958 Maryland					
	ryland how		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits					
	8a-1 s	Director	Maryland N/A		Baltimore		1 X Yes 2 No					
	with the	Dire	10e. Street and Number 4123 Falls Roa	nd Ant A	10f. Zip Code 21211	10g.	Citizen of What Country?					
	ns 23	Funeral			Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	USA 14. Race - American Indian,					
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show it it inter 27 is marked other than "natural", or other traumatic event, the Medical Example interest collised at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 □XNo	If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 X No Specify:	Black, White, etc. Specify: White						
5-0	72 ho inatur	eted	15. Decedent's Educ (Specify only highest grade	cation 16a. Dece	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	orking 16b	. Kind of Business/Industry					
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N	2 should be filed within and Mental Hygiene. Is marked other than aumatic event. Its Mental Mental aumatic event.	Be Co	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid						
/lan	uld be Vental irked c	To B	Joseph James Kr	ieger	Bart	oara Jean C	ameron					
Maryland	and 2 should leath and Men n 27 la marke ler traumatic	Ċ	19a. Informant's Name/Relationship (Type Vickie L. Norman/s		ing Address <i>(Stree</i> t and Number or R 08 Falls Road Ba							
ore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 li any injury or other tra once.		20a. Method of Disposition	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)		. Location - City or Town, State					
Baltimore,	. Pages tment of I tant: If it		Metro Crematory, Inc. 6/24/05 Baltimore, MD									
Bal	permit. Departr Importa any inje		21. Signature of Fun (S) The Communication of Maryland, Inc. Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228									
	100		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
	Physician		Immediate Cause (Final disease or condition	Cirrhosis of the L			Onset and Death					
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	TTACT							
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease of n,u y that initiated events									
0,	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as a consequence of):								
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9 X	death certificate b a attending physic d for use as the b	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of delivery					
О. Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Month Day Year							
۳,	s that med b e deta	by Pł	Part II. Other significant conditions cor	ntributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?					
Records,	w require been sig should b	ted				1 🗆 Yes	2 No 3 Probably 4 Unknown					
ecc	law r nas be e 2 sh	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
H	: The licate hat, page					performed NZ Yes 2□	? death? No 189es 2 No					
Vital	aician: The law certificate has b irector, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	eath (Check only one) Home 5 Aesidence	6 Other (Specify) D-					
of	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how i	- MCGLIG					
ion	Mtendin death, ctor: Aft y the fun	atlo	1 Natural 5 Pending Investigation	(Month, Day Your) Highly	M 1 ☐ Yes 2 ☐ No							
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, late)					
	ne Hospil 24 hour ne Funer pletely fill	Medical		sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.								
	To the within 2 To the complet	Ň	29b. Signature and fitle of certifier	1.	29c. License number OCME		Date signed (Month, Day, Year)					
•			WY VI	AN IN			Tune, 22, 2005					
			30. Name and address of person who co	ompleted cause weath (Item 23a) (Type		Baltimor	e, Maryland 21201					
B	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature								
	Regist	rar	2000 0 0000	G. H. And	244							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2005 Catherine Oma Kraus June 27 5:00a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 990 Eckard Court Westminster Carrol1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct 15 Birthplace (State or Foreign Country)
 WV **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min 217-66-4287 Yrs. Director 1930 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 le marked other than "netural", or Items 23e or 28e-f ehow other treumatic event, the Netheal Exprenent must be notified at Md Carroll Westminster 1 ☐ Yes 2 🕅 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 990 Eckard Court 21158 USA death Funerai 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "netural", or Iten eny injury or other treumatic event, the Medical Example. Once. Black, White, etc. 1 ☐ Yes 2 ₩ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Š 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Delma Malone Emma Louise Blower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted Kraus (son) 990 Eckard Ct., Westminster, Md 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md 6-29-05 Lorraine Park Cem. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Harght Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ebetro Vascular accident Priysician cley 15 disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed the burial-transit signed by the attending physician and be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has After this certificate To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certified 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home SEResidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Ecritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23443 west-winster MD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bullimore Bird 31. Date filed (Month, Day, Year) JUN 2 8 2005 32. Paistrar's Signature State Registra

2005

JUNE 25,

HELENA KAHLAN

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2005 Katherine Kibec 1:00 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 132 Bon Air Road **Baltimore** Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, July 23 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 X F 62 217 40 2124 Ukraine Director Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 28e-f show Examiner total be notified at Baltimore 1 ☐ Yes 217 No Maryland Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 132 Bon Air Road Items 23a 21225 U.S. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Narried ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed marked other than "natur imatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) years Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental John Gavrilenkowsky Maria (not available) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 Item 27 John Kibec Husband 132 Bon Air Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 6/25/2005 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 23a Part . Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metaslalie Briast **Physician** Marthe resulting in death) /Medical Due to (or as a consequence of) Examiner 1991 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the all P.O. I 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 🗆 **X**o 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes & No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident death. after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) da D30568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 DAKWOOD RD. SE 204 CKA Burnie MD.21061 DR. SHOBHA D. REDDI 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State Registrar

HERINE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CLAYTON ROBERT JUN 22 2005 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Min. Hours **Director** 212-73-1477 April 24, 2005 Marvland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Cumberland Fayetteville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 844 Tamarac Drive. 28311 death v U.S.A Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, Ite Madical Example. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) never worked N/A never worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Jeffrey Carl Lloyd Kathryn Elizabeth Whitmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jeffrey Carl Lloyd 844 Tamarac Drive. Fayetteville, NC 28311 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 06/29/2005 **Bayview Crematory** Baltimore, MD 22. Name and Address of Facility Slack Funeral Home, P.A. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Soler the disease, shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final Physician PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the as use a IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? certificate 1 X Yes 2 No 2 X No To the Hospital or Attending Physician: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗓 No 1X Inpatient 0 2 ER/Outpatient 3□ DQA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) filled in by determined 4 \ Homicide TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 06-24-2005 MD048338-L (PA) address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER 3 MAUREEN L. TATE LTC MC USA BETHESDA MD 20889-5600 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

			artment of Health and Men	tal Hygiene 2005 21289
Physic	cian	Decedent's Name (First, Middle, Last)	171	Date of Death Month Day Year 3. Time of Death
/Med Exam	lical	Richard T. Laughard 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ne 25, 2005 3:40 a ^M
LABIII	IIIĢI	Gilchrist Center	Towson	Baltimore
Funera Directo		5. Social Security Number 1 8 - 58 - 2974 5. Social Security Number 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. G	Oate of Birth Month Day Year) 15/52 9. Birthplace (State or Foreign Country) Pennsylvania
σ		Usual Residence of Decedent		
Maryla f shov	to		sedale	10d. Inside City Limits 1 ☐ Yes 2 🗷 No
th the or 28e	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
s 23a	rai	8545 Pulaski Highway Lot 4/A	21237	USA
Iryland 21215-UU36 hould be filed within 72 hours atter death with the Maryland of Mental Hygiene. marked other then "naturel; or Items 23a or 28e-f show matic event, the Medical Examiner must be notified at	Funerai	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	
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~ o ~ o >	To Be	Theodore Joseph		st, Middle, Maiden Sumame) Laughard
Taryla 2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir		ute Number, City or Town, State, Zip Code)
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Baltimore, Marylat permit. Pages 1 and 2 should b Department of Health and Menta Importent: If them 27 is marked any injury or other treumatice any injury or other treumatice.		21. Signature of Funeral Service Licensee	aczorowski in Funer	al Home P. A.
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Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Me tas fatic fasc.		Interval Between Onset and Death Mon MS
/Medica Examine		resulting in death) Due to (or as a consequence of):	, , ,	Month
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at the d by the	hysi	1 Ves 2 No 4 Pregnant at time of death 5 L		
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The tay ate has page 2	Completed			24a. Was an autopsy findings available prior to completion of cause of death? □ Yes 2 № No
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g Phye er this ieral dii	n: To	27 Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. I	5 ☐ Residence 6 🗗 Other (Specify) Haspie =
JIVISION or Attending after death. Director: Alte	catio	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
DIVISION To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Atler completely tilled in by the tuner	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, stribullding, etc. (Specify)	et, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
a Hosp 24 hou a Fune etely til	edical	29a. Certifler (Check only one) (Check	occurred at the time, date and place, and divestigation, in my opinion, death occurred at	ue to the cause(s) and manner as stated, the time, date and place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier How Supplementary	29c. License number	29d. Date signed (Month, Day, Year)
			D0061199	June, 25, 2005
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Tas on Black, 6565 North Charles 5	+, Suite 203, Baltimor	c,MD 21204
S Regis	tate trar	31. Date filed (Month, Day, Year) 11 N 2 8 2005 32. Signature	arte	

LAUGHARd, RICHARd 4/35/65 @3:40AM

			1 - For State Registrar	State of M	aryland /		artment o		and Mental F	lygiene	00	5 2	1200
	Physic /Medi		Decedent's Name (First, Middle Far)	Stanl	e4		L	-illy	2. Date of Month	Death Day		Year 2005	3. Time of Death
	Funeral	ner	4a. Facility Name (If not institution The Johns Ho 5. Social Security Number 218-62-9926	pkins Hos	501 tall e (In yrs. last b 48	oirthday) Yrs.	4b. City, Tow BOLL + If Under 1 You Months Da		24 Hrs. 8 Date of Min. 8 (Month,	Birth Day, Year)	. County of		ce (State or Foreign
	Director Mode Mode		Usual Residence of Decedent 10a. State 10b. County	K	10c. City, To	wn or Lo			ĴULY	8, 19	56	Mary]	. Inside City Limits
	or 28e-f	Director	MD 10e. Street and Number		Baltir	nore	10f. Zip Coo	le		10g. Citi	izen of Wh	hat Country	1 XYes 2 □ No
9800	within 72 hours after death with the Maryland ene. than "neturel; or items 23e or 28e-f show to Modical Exertiret is wit be rollined at	by Funeral	1218 Sargeant. 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 1 ☐ Yes 2 X If Yes, Give Year or Dates:		1			gin? (Specify Yes or , Puerto Rican, etc.)	No-		A - American , White, etc Whit	·
Maryland 21215-0036	T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, I	t grade completed) College (1-4or 5		(Give life.	dent's Usual Ockind of work do DO NDT use re Velder	ne during most tired)			Const	iness/Indus	
larylanc	d fa d	To Be	Robert W. Lill	Y ip (Type, Print)				Nanc	er's Name <i>(First, Midd</i> Y Lee Fish er or Rural Route Num	nber, City o			ode)
Baltimore, N	permit. Pages 1 and 2 should Department of Health and Men Important; if item 27 is marke any injury or other treumatic <u>once.</u>		Christina Lilly 20a. Method of Disposition 1	3 □Removal from State	20b. Place cemete	of Dispo	Sargear sition (Name of natory or other Wash. (olace)	Baltimore Date 6/29/2005	20c. Lo		23 ity or Town Mary	
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service I	. Heder	ma	⊸72 5	0 Wash	dress of Facilit autman naton	Funeral Ho	ridae	leadov	210	75
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68760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying (1986), 1986, 1987,	c. Due to (or as	a consequence	of):							
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	Registr	ar	วักษร	3 2005	w St.	As	me						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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eral ctor			Sex 7. Age 1 ☐ M 2 ☐ F	(In yrs. last birth	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day Nov • 27	1932	9. Bi	irthplace (State or Foreig Country) ermany
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336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic avant. The Medical Examinent is usaffer at 2008.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	o 13.	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No		(Specify Yes or No erto Rican, etc.)	9- 14. Rad Bla Specif	ce - Americ ck, White,		
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Maryland	2 shou and M is mar sumat	-	19a. Informant's Name/Relationship		19b. Mail	ng Address (Stree	1		er, City or Town,	State, Zip	Code)	
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Baltimore,	permit. Pages 1 Department of He Important: If itar any injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		20b. Place of Disponentery, cree Oaklawn	osition (Name of matory or other pla		Date 0 / 2005	20c. Location Baltimo	-		
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Jason Black, 6601 North Charles ST, Baltimore and 21204			(h						01177	J	une, 20	7, 2003
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Registrar JUN 2 8 2005 Registrar & Short D			0		31. Date filed (Month_Dav. Year)	32. Beh	istrar's Signature	1361	IIMOIE DOT	2 2120		
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05~04205 TIMOTHY MILLETT amend item#1, unpend #23a, 27, permit 1,040, 5 Ensure All Copies Are Legible. MHW State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 0 5 Certificate of Death 1. Decedent's Name (First Middle, Last)
Timothy William Millette
Timothy Millett 2. Date of Death Month Day **Physician** 11:48 A M JUNE 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BELATR HARFORD CO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
July 21, 1957 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days X M 2□F Months Hours 47 219-72-9112 Yrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exertine must be notified at Maryland 1 ☐ Yes 2 ₹ No Directo Harford Forest Hill the 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? ö Items 23a 1702 High Point Road 21050 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 'naturel', or 1 ☐ Yes 2 XNo Specify: Specify: White Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene, Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Self Employed is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Joseph W. Millette Ruth Braden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is Michelle A. Millette, Wife 1702 High Point Road Forest Hill Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) 5 06/24/05 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Cremation Society Of Maryland
299 Frederick Road Baltimore, any in Thomas Gregor Inc. Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed and Due to (or as a consequence of): sician a burial-1 P.O. Box 68760 Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 3 □Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No autopsy performed? page 1X Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 XNatural 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation М the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by 4 | Homicide filled within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) **OCME** JUNE 21, 2005 0 who completed the of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person

31. Date filed (Month, Day,

Registrar's Signature

			For State	State of Maryland		nt of Health a	nd Mental H			21205
	Physici	20	Registrar 1 Oepadent's Name (First, Middle, La	st) Macan	Certifica	le oi Dealii	2. Date of D	Reg. Ne eath Day	000	3. Time of Death
	/Medic Examir	al	4a. Facility Name (If not institution, giv	e street and number)	4b. Cit	y, Town, or Location of	June	24, 2	005 County of Death	5:30 a. M
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	Funeral Director	2		Sex 7. Age (In yrs. last	Yrs. If Und Month	er 1 Year If Under 2 s Days Hours		irth Jav, Yearl 5 - 5	6 Mo	aplace (State or Foreign untry) USY Jand
	the Maryland 28a-f show notified at	ō	10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limits 1 ★es 2 No
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9	or Ite	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 S O		edent of Hispanic Originatify Cuban, Mexican, 2 No Specify:	Puerto Rican, etc.)	10-	Black, White	, etc.
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ore,	ges 1 au t of Hea lf item or othe		20a. Method of Disposition M Burial 2 Cremation 3	20b. Place	e of Disposition (Netery, crematory of	ame of other place)	Date	20c. Lo	ocation - City or T	Town, State
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Вох	death certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3 ☐Ectopic			:	23d. Date of deliv Month	very Day Year
P.O.	that the de ed by the detached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	- J Ottler (specify/				
	S C 00	by	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying	cause given in Part I.		tobacco u		the cause of death?
Records,	- Q TO	Completed					24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
al R	iician: The law certificate has rector, page 2 !						1X Yes	ormed? 2 ☐ No	death?	2 □ No
f Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? ↑★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🛣 ER/	Outpatient 3 🗆	Othor	of Death (Check only sing Home 5 Re		6 □Other (Speci	ify)
Division of	ling After funer		27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	b. Time of Injury	28c. Injury at Work?	28d. Describe			
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	To the within to the comp	Σ	29b. Signature and title of certifier	· -OM	2	9c. License number OCME			ne 24,	
1	9		30 Name and address of person who	completed cause of death (Item 23)	ta) (Type, Print)					
(7 "		Pala ca Ac	Ench-Pallak	MD 111	Penn Stree	et Baltim	ore,	Marylan	d 21201
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JUN 2 8 2	32 Registrar's Signature	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registra Reg. No. 2 Certificate of Death 2 Date of Death dent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year **Funeral** 1 🗆 M Yrs. rand Director 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State works ral, or Itams 23c or 28e-f shov Exercites (wall be notilied at Yes 2□No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death Funera Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Never Married 2 Married Yes 2 No f Yes, Give Year or Dates: 1 Yes 2 40 Baltimore, Maryland 21215-0036 Specify. cify þ 4 Divorced 3 Widowed "natural", Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation other treumatic event, the Madical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) entany (Secondary (0-12) and Mental Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden and Mental 9-1-11 or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number Department of Health a Important: If Itam 27 is any injury or other tree once. Method of Disposition Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 10 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dynas, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heart month Physician zi.luv /Medical Due to (or as a consequence of): **Examiner** ongenitz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): by Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? ō 5 Other (specify) P.0. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. pe 2 ☑No 3 ☐ Probably 4 ☐Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 2 No 1 TYAS Yes To the Hospitel or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 ☑ No 2 ER/Outpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 🔲 Yes 2 No investigation death. 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a 1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

Thom

W. Reid

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

w A Agores

Johns He

32. Registrar's Signature

600 N. Wolfe

			1 State of	Maryland / Depa		lealth and Men	tal Hygiei	ne _	21207
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	runcate or		Reg. I	2005	21291
	Physic		Salim Malouf			A	Month [Day Year	3. Time of Death
	/Med Exami		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, o	Ju or Location of Death		2005 4c. County of Death	5:56 p ^M
			GREATER BALTIMORE MEDIC	CAL CENTER	TOWSON			BALTIMORE	
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60	that the de ed by the a detached	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown	at time of death 5	Other (specify)			Month	Day Year
/ a.	es that thighed by	y Ph	Part II. Dther significent conditions contributing to death	but not resulting in the un	derlying cause give	en in Part I. 2	3e. Did tobacco	use contribute to th	e cause of death?
rds,	quires en signe uld be	Completed by Physician/Med	Circhosis	COAGUL	pathy		1 ☐ Yes 2		ably 4 Unknown
Record	aw requir as been s 2 should	piete	Genal failur	P SPO	fic o	hook 2	∮a. Wasan	24b. Were autor	osy findings available
	nician: The lav certificate has rector, page 2	mo;	(V)	, 54	116 3.	TUCA	autopsy performed?	death?	osy findings available inpletion of cause of
Vital	Phyaician: this certifica ral director, p	Be (25. Was case referred to medical examiner?			26. Place of Death (Che	Yes 2 N	1 ☐ Yes	2L NO
K 2	Phyai this c	2	1 ☐ Yes 2 No Hospital: 1 Impa		3□ DOA Cthe	ar: 4 ☐ Nursing Home 5	Residence	6 ☐Other (Specify)
	ding l	ion	27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of Ir (Month, L	Jury 28b. Time of Injury	28c. Injury Work	at 28d. D	escribe how inju	ry occurred	
Division	Attender deat	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of I	njury - At home, farm, stre		res 2 □ No	cation (Street a	nd Number or Rural	Courte Mumber
ρί	al or a after	Certification:	4 Homicide determined building,	etc. (Specify)	ot, radiory, diffee	Cit	y or Town, Stat	e)	noute Number,
	ospit hours unera ly fille	cai (29a. Certifier Check only 2 Medical Examiner: On the basis	st of my knowledge, death	occurred at the tim	e, date and place, and du	e to the cause(s	and manner as sta	ated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	one) 2 I medical Examiner: On the basis	of examination and/or inve	estigation, in my op	inion, death occurred at th	ne time, date an	d place, and due to	the cause(s)
	To To Cor	<	29b. Signature and title of certifier	N	29c. License	number	29d. Da	ite signed (Month, E	Day, Year)
	7,	1	20 Name and address of a second	D CONTRACTOR	1 000	158087	&	123/05	
	8		30. Name and address of person who completed cause of	569 ALC	harles	A Chito	601	TOUTCA	MA
	Sta		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	10/1/10	Juil C	VU	100030	1)
	Registr	ar	JUN 2 8 2005	was It Ap	wie				

				artment of Health and Menta	al Hygiene	298
	Physic /Medi		MARK MOOSE	J Mo		me of Death
	Examir Funeral	ner	Northwest Hospital Center	4b. City, Town, or Location of Death Randallstown If Under 1 Year If Under 24 Hrs. 8 Dal	4c. County of Death Baltimore ste of Birth 9. Birthplace /S	Into or Foreign
	Director		5. Social Security Number 217-16-2349 6. Sax 7. Age (In yrs. last birthday) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	Months Days Hours Min. (Mc	onth, Pay, Year) t 4, 1923 Maryland	
	the Maryla 28a-f sho	Funeral Director	Maria 1 D 1 1			de City Limits
	23e or	alDI	8807 Meadow Heights Road	21133	United States	
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other then "neturel", or items 23e or 28a-f show other treumatic event, the Medical Examinational December 11.	by	3 XWidowed 4 □ Divorced Year or Dates:	Was Decedent of Hispanic Origin? (Specify Ye f Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 X No Specify:	es or No- etc.) 14. Race - American India Black, White, etc. Specify: White	in,
Maryland 21215-0036	I within 72 h jene. r then "netu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th 16a. Deceding (Give life) College (1-4or 5+) Mechanical	dent's Usual Occupation kind of work done during most of working OO NOT use retired)	16b. Kind of Business/Industry	
פַ	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)		Automobile Middle, Maiden Sumame)	
ylaı	should be and Mental I marked o	70 8	Chester Moose		offman	
	1 and 2 st Health and tem 27 Is n		Karen Harrington (Daughter) 8857	g Address (Street and Number or Rural Route Widmer Road, Lenexa,		
altimore,	Page nent o int: If iry or			orial Park June 25,2	20c. Location City or Town, Sta	
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee	Name and Address of Facility Loring 28 Liberty Rd., Randa	Byers Funeral Dire	ctors,Ir
8760,	Physician and /Medical Examiner transit the printing transit	dical Examiner	23a. Int. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary, leading to fine districtions. Enter Underlying Cause, Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	TRUCTIVE PULMONAR	Interva Onset	imate I Between and Death
O. Box 6	requires that the death certifics seen signed by the attending ph hould be detached for use as t	Physician/Med		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day	Year
rds, P	w requires that s been signed b should be deta	leted by Pł	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I. 23e	Did tobacco use contribute to the cause The state of the caus	of death?
VITAL Records,	The law ate has b page 2 s	e Complet	25. Was case referred to medical	1 🗆	a. Was an autopsy findir prior to completion death? Yes 2 XNo 1 Yes 2 X No	ngs available of cause of
ō	Phys this al di	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Pending investigation 3 Suicide 6 Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Time of Injury 28b. Place of Injury 28b. Time of Injury 28b. Place of Injury 28b. Time of Injur	28c. Injury at Work? M 1 Yes 2 No	k only one) ☐ Residence 6 ☐ Other (Specify) scribe how injury occurred sation (Street and Number or Rural Route N	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		4 ☐ nomicide building, etc. (Specify) 29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death	City	to the cause(s) and manner as crated	
	1	Medical	29b. Signature and title of certifier The signature and title of cert	29c. License number	e time, date and place, and due to the cause 29d. Date signed (Month, Day, Yea JUNE 23 ^{RO} , 20	r)
	ולן		30. Name and address of person who completed cause of death (Item 23a) (Type, F	JORINGEN I TITE	HTA	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 8 2005	KANCAUSTOWN MC	S 21133.	

			1 - For Stete Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H		-	giene	. 21200
	Physic	an	1. Decedent's Name (First, Middle, La					2. Date of De	nath Day Yea	3. Time of Death
	/Medi	cal	Lois Weller Men 4a. Facility Name (If not institution, giv					JUNE	25 20	05 1.20 PM
	Exami	ier	SAINT AGNES	HEALTI	HCARE		IMOR	E	4c. County of De	eath
	Funeral Director		5. Social Security Number 6. S 215-40-3059 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. last birthday 64 Yrs.	Months Days	If Under 24 H Hours Mi		19. E 19. Year) 1941 Ma	sirthplace (State or Foreign Country) aryland
	yland how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	h the Marylan or 28a-f show a notified at	ctor	Maryland Baltimo	re	Ca	tonsville				1 ☐ Yes 21公 No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	ŕ
	ns 23	Funerai	1412 Ridge Road	12. Was Decedent	Ever in II S 13		228	(Crosify Vac or No	U.S.A	
9	after d or Itan militer		1 ☐ Never Married 2 🔀 Married	Armed Forces?	'	Was Decedent of H. If Yes, specify Cuba		erto Rican, etc.)	Black, WI	nerican Indian, nite, etc.
003	hours after death with the Maryland tural', or Itams 23a or 28a-f show at Examiter must be rollified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: W	hite
15-("nai	lete	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted)</i>	16a. Dece	edent's Usual Occupa a kind of work done of DO NOT use retired	ation during most of w	orking	16b. Kind of Busines	ss/Industry
212	filed withir Hygiene. other than ant, it e M.	Completed	Elementary/Secondary (0-12)	College (1-4or :	0+)	memaker	"		Own Hom	ie
nd	al Hygie I other	Be C	17. Father's Name (First, Middle, Last				18. Mother's N	ame (First, Middle,	Maiden Sumame)	
yla	2 should be f and Mental lis marked of reumatic eve	7	Harry Frederick		.,			ty Clark		
Maryland 21215-0036	D = C =		19a. Informant's Name/Relationship (Charles Merrick	_{Туре, Print)} (Husband)					er, City or Town, State	
	t Health tram 27 other tr		20a. Method of Disposition	(Husballu		osition (Name of matory or other place		Date Date	Maryland 2	
BO	Page: ient of nt: If i		1 ဩBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif			matory or other place Cemetery		9-2005	Woodlawn,	
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		21. Signature of Funeral Service Licer	1500		2 Name and Address	o of Facility			Inc. ryland 21228
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do not en	530 Edmono ter the mode of dvind	dson Ave	c Caton	sville, Ma	ryland 21228
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	NIADIA		ANCE			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		11100			DNE WEE
-	LAdillilei	-	Sequentially list conditions,	b. Due to (or as	a consequence of):					
$\sqrt{}$	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence ory:					
,	ate be executed hysician and the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequence of):					
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai	(d						
9	leath certific attending pl	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy					
Box	death a atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1□Live birth 4□Pregnant at	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of di Month	elivery Day Year
P.O.	that the death hed by the atter detached for u	hys	9 ☐ Unknown •	9□ Unknown						
Ś	be of	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause give	on in Part I.		bacco use contribute	\ .
Ö	w requir been si should	etec						-		robably 4 Unknown
Division of Vital Records,	he lav e has age 2 :	Completed						24a. Was autop	sy prior to	completion of cause of
ital		0	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only or	2/2No 1 Ye	s 2 No
) t	Physician: this certific al director,	To B	examiner? 1 Yes 2 No	Hospital: Inpatie	nt 2 ER/Outpatie	nt 3 DOA Othe			ence 6 Other (Spe	ecify)
o uc	ding P	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Work		28d. Describe h	ow injury occurred	
/isic	f or Attandii after death. Diractor: Al in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined		ury - At home, farm, st		′es 2 □ No	28f. Location (S	treet and Number or F	Jural Route Number
Ö	al or safter safter al Dira	Certification:	4 Homicide determined	building, etc	c. (Specify)	201, 1201019, 011100		City or Tow		arai riodio rianiber,
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical (29a. Certifier Certifying Ph (Check only one) 2 ☐ Medical Exam	ysicien: To the best of niner: On the basis of and manner sta	of my knowledge, deat examination and/or in	n occurred at the time vestigation, in my op	e, date and plac inion, death occ	e, and due to the durred at the time, o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	A .		29c. License	-	2	29d. Date signed (Mon	th, Day, Year)
	/		> offinix v	lua M	ソ	P18	3606		JUNE 2	6,2005
	13		30. Name and address of person who	100	CATON	AVE.	BAL		E, MD	
yls.	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 8 26	32. Tegistra	ar's Signature	sele				

MERRICK

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			1 - For State Registrar	State of	Marylan	_	artmen				Mental Hyg	giene	105	21200
		Š.	Decedent's Name (First, Middle,	Last)							2. Date of Dea	ith		3. Time of Death
R	Physica /Medi		Erma Catheri	ne McDonal	Ld						Month June	25	2005	11:50P M
	Examir		4a. Facility Name (If not institution,	give street and numb	oer)		4b. City,	Town, or	Location	of Death		4c. Cou	nty of Death	
w _e			5905 Johnnycak	e Road			Bal	Ltimo	ore				Balti	more
	Funeral			6. Sex 7. 1 ☐ M 2 🖾 F	Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign ntry)
	Director		212-20-6130	1 141 2 2 3 1	79	Yrs.					March 5	,1926	West	Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mary f sho	0	Maryland Balti	m 0 w 0		7	0 - 1 - !							1 ☐ Yes 2X No
	28a	Director	10e. Street and Number	more			3altin					10g Citizen	of What Cou	ntry?
	3£ or		5905 Johnnyca	ke Road				212	207				J.S.A.	
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23c or 28e-f show other than "natural", or Itams 23c or 28e-f show event, the Medical Exam net matter positive at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	Was Deced			gin? (Sp	ecify Yes or No- Rican, etc.)		Race - Ameri	can Indian,
9	after or Ita		1 ☐ Never Married 2 ☐ Marrie								Rican, etc.)	E	Black, White,	etc.
93	ours Feat,	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1□ Yes 2	IXI No	Specify:			Spe	cify: Wh:	ite
5	72 h 'natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usua kind of wor	k done d	urina mos	t of work	ina	16b. Kind o	Business/In	dustry
2	within ene. than "	ldm	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired;						
2	e filed within al Hygiene. othar than ' vant, the Me		10 17. Father's Name (First, Middle, L	ant)		Hon	nemake		10.11.11				Home	
and	outd be f Mental P arkad ot atic evan	Be		351)							e (First, Middle,		iame)	
Ž	2 should be and Mental la markad (aumatic ev	Ţ	Luther Cassell 19a. Informant's Name/Relationshi	in (Tuna Brint)		10h Maille		/C4			e Mclaus			
Maryland 21215-0036	りたっち		Jeffrey S. McDo:	, , , ,							Al Route Number			
က်	1 and Health tem 27		20a. Method of Disposition	naid (Son		lace of Dispo	ake Fo		Cou		Baltimo ₁ Date		ry Land In - City or To	
Baltimore,	ages int of t: If it		1 ⊠ Burial 2 ☐ Cremation		ate Mea	emetery, crer adowric	natory or ot dge	her place	,					
量	artme ortani injury		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Mem	orial	Park 2. Name and	1 Addros			-2005	Elkri	dge, N	Maryland
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		Hohana	9/VL	5	Wi	tzke	Fune	ral	Home	of Cato	onsvil	le, Ir	nc. and 21228
			23a. Part1. Enter the disease, or	omplications that cau	sed the death	. Do not ent	o 30 Ed er the mode	monc of dvinc	SON such as	Ave.	Catons or respiratory arr	7ille,	Mary]	Approximate
			Immediate Cause (Final	nly one cause on each	h line.		201.6							Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	as a consequ		201,2		0070	in	ma			
	Examiner				us a consequ	ioneo or,								
4		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	ence of):							-	
V	cuted	Examine	that initiated events	G.										
O	e exe		resulting in death) Last	Due to (or	as a consequ	ience of):					-			
8760,	cate be executed physician and the burial-transit	dicai		d										
9	e as	Mec	IF FEMALE:					-						
Вох	death certifi e attending I id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal	death 3	Ectopic pre						Date of delive	*
0	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnan 9☐Unknowi	t at time of de n	ath 5	Other (spe	cify)					AIOIIII	Day Year
<u>~</u>	The law requires that the de ste has been signed by the bage 2 should be detached	Ph	Part II. Dther significant condition	s contributing to deat	h but not recu	Iting in the u	adorhijaa oa	uso anua	n in Dart I		220 Did to		anteibusto to th	ne cause of death?
Vital Records,	signed be del	d by				ming in the di	lacity ing ca	uso give	i ii r citti.		1 □ Ye			ably 4 Unknown
Ö	w require been sign	ete										- 1	-	
Ę	has has	Completed									24a. Was a autops perform	y	prior to cor	psy findings available npletion of cause of
_ _												No	death?	2□ No
Ξ	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Other	~		Check only on			-
of	ਰੂ ≑ ਲੂ	: To	1 Yes 2 No	1 Linpa		R/Outpatien 28b. Time of		c. Injury	4 U Nui		ne 512/Reside 28d. Describe ho			"
o	ding Ph h. After th funeral	tion	1 SNatural 5 ☐ Pending	28a. Date of I. (Month,	Day Year)	Injury	M	Work'	at ? es 2 □ N		ed. Describe no	w injury occ	urrea	
Division of	Attanding r death. sctor: After by the funer	fica	3 Suicide 6 Could no	t be 290 Place of	Injury - At hor	me, farm, stre			03 201		28f. Location (St.	reet and Nur	nher or Rura	I Route Number
<u>S</u>	after Dira	Certification:	4 Homicide determin	building,	etc. (Specify))	oot, idotory,	omoo			City or Town	, State)	noer or ribra	rriodie Namber,
	To the Hospital or Attandin within 24 hours after death. To the Funaral Diractor: Aft completely filled in by the fur		29a. Certifier 1 Certifying	Physician: To the be	est of my know	viedge, death	occurred a	t the time	e, date and	d place, a	and due to the ca	use(s) and i	manner as st	ated.
	n 24 I	edical	(Check only 2 Medical Ex	xaminer: On the basis and manner	s of examinati	ion and/or inv	estigation, i	n my opi	nion, deat	h occurr	ed at the time, da	ate and place	e, and due to	the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	, 1	12		29c.	License	number				ned (Month, I	
			- Ednl 6	1 Kow	ak		D	34	95	1		June	28	2005
	2		30. Name and address of person w	no completed cause of	of death (Item	23a) (Type, I	Priot)	0	21.		1	1	11	2005
	7		EDMUND	P T lose	me	405	TXX	K	eld	wde	100	IL II OV	1/19 mi	>2128
	Sta	-	31. Date filed (Month, Day, Year) JUN 2 8	2005 32. gi	istrar's Signatu	ure								
	Registr	ar	JUN & O	7007	Istrar's Signati	J. Se								

State of Maryland / Department of Health and Mental Hygi

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			* Hagistrar					Certi	iicaii	9 01 1	Dealli			Reg. No.	.000	۳.	. 1 0 0 1
	Dhysic	ion	Decedent's Name (First, N		•								2. Date of D	eath Day	y Ye	ar	3. Time of Death
	Physic /Med		WILLIAM	1	MOR	GAN							June	2000		55	5:13p
	Exami		4a. Facility Name (If not instit		e street and nu	ımber)			4b. City,	Town, o	r Location	of Death		4c.	County of D	eath	
			Memori	al	Ho	spid	Lo			CLS	tor	1			Tall	00	+
	Funeral		5. Social Security Number	6. S		7. Age (In			If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth	9.	Birthpla	ice (State or Fore
	Director		219-40-6908	1	∑ M 2□F		61	Yrs.	AIOHIUIS	Days	Hours	MIII.	7/12/1	943		Country	MD
	ъ.		Usual Residence of Deceder				-										
	arylau shov		10a. State 10b. Co			100	. City, Tow		ition							100	d. Inside City Limi
	Ba-f	양	MD Tall	oot			Witt	man									1 ☐ Yes 2 ∑ ☐ N
2	if th	lre	10e. Street and Number						10f. Zip					10g. Citi	izen of What	Countr	y?
9	th w	a	PO Box 29						2.	1676)				USA		
Morgan	1215-0036 within 72 hours after death with the Maryland ane. than "natural", or Itams 23s or 28s-f show the Maryland Examinating the rediffed at	by Funeral Director	11. Marital Status		12. Was Dec Amed F	edent Ever	in U.S.	13. Wa	as Deced	lent of H	lispanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W		
0	afte or It	F	1 ☐ Never Married 2 🛱			2 🗌 No			Yes 2		Specify:				Specify:	whj	
	Sours sours LEX		3 Widowed 4 Divo	rced	Year or I	Dates:									зресну.	WII	
	72 h	Completed	15. Dece (Specify only hi	dent's Ed ghest gra	ducation ade <i>completed)</i>)	16a	. Deceder (Give kir	nd of wor	k done d	durina mos	t of work	ing	16b. Ki	ind of Busine	ss/Indu	stry
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5	be find Hall Hall Hall Hall Hall Hall Hall Hal	Be	17. Father's Name (First, Mid William Samu			T ₂₀							e (First, Middle te Blo				
Ō	View ould warke	ဥ				JI.			_								
	Aar 2 sh and is m		19a. Informant's Name/Relat Mrs. Betty Mo		* .								al Route Numb	per, City o	r Town, State	э, <i>Zip С</i>	(ode)
Nilliam	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Mudical Examination in still be rediffed at once.			Jigai	I / WII						ttman		21676				
3	Ord Jes 1 of H if ita		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremat	ion 3 🗆	Removal from	State		ry, crema	tory or of	ther plac			Date		cation - City		
	Pag ment ant:	1	4 □ Donation 5 □ Other	x (Specif	y)	(Chesa	-					/2005		vensv		•
	Balt permit. Depart Import any inj		21. Si nature of A neral ten	vice Doer	rsee	мС	1364	22. 1	Name and	d Addres	ss of Facili	y Sin	gleton	Fune	ral H	ome	P.A.
	— #QF#9		Muse	di	llas								en Burr		D 2106	1	
			23a. Part1. Enter the disease shock, or heart failure.	e, or com List only	plications that one cause on	caused the deach line.	death. Do	not enter	the mode	e of dyin	ig, such as	cardiac o	or respiratory	arrest,		Δ	Approximate nterval Between
4	Physician	a)	Immediate Cause (Final disease or condition		A	LOTE	M40	CAR	DIA	, 11	UFAL	20-	lant			C	Onset and Death
	. /Medical		resulting in death)	-		(or as a cor			٥١١٨٠	- ' '		- 1	107			+	
	Examiner		0	- 1	b												
		ner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	J		(or as a cor	sequence	of):									
	cuted	Examiner	that initiated events		c											1/1	
	0 exe		resulting in death) Last	- 1	Due to	(or as a con	sequence	of):									
	Box 68760, anth certificate be executed attending physician and for use as the burial-transit	an/Medical			_ d										-		
	68 riffica ng ph	Aed	IF FEMALE:														_
	OX th ce th ce tendii	an/h	23b. Was decedent pregnan		23c. If yes, ou	tcome of prebirth 2 1	egnancy Fetal death	3 □E	ctopic pre	annancv				2	23d. Date of	delivery	
	O. E		in the past 12 months? 1 ☐ Yes 2 ☐ No			nant at time			ther (spe						Month	D	ay Year
	P.O. B that the deatl ed by the atter detached for	by Physici	9 Unknown		3 O O O												
	cords, P	by F	Part II. Other significant con			leath but not	resulting i	n the unde	erlying ca	ause give	en in Part I		23e. Did	tobacco u	se contribute	to the	cause of death?
	oquire on sij	ed	HUDERT										1 🗆	Yes 2[X No 3□	Probab	oly 4 Unknow
	as bee	Completed	HYPERC	ite @	STERRA	EMIA	-						24a. Was		24b. Were	autops	y findings availab
	Re(The lave te has age 2	E O										-	auto	ormed?	prior i	o comp	y findings availab pletion of cause of
	tal	a)	25. Was case referred to me	dical							26 Place	of Death	1 ☐ Yes		1 🗆 Y	es 21	□ No
	Visicia s cer	To B	examiner? 1 ☐ Yes 2 🗷 No	-	Hospital:	Inpatient	2 XERVOL	itnatient	3[] DO.	Δ Othe			me 5□Res		Othor (C	nacifu)	
	Of Physeral Geral Control	J.:	27. Manner of Death	1		of Injury oth, Day Yea		Time of		Bc. Injury Work			28d. Describe			Jecliy)	
	On ading th. : Afte	tion	1 Natural 5 ☐ Pe 2 ☐ Accident inv	nding estigation		ith, Day Yea	r)	Injury	М		k? Yes 2. □	No					
	Division of Vital Records, P.O. E for Attending Physician: The law requires that the dea after death. Diractor: After this certificate has been signed by the at in by the funeral director, page 2 should be detached it.	fice	3 ☐ Suicide 6 ☐ Co	uld not b	e 28e. Place	of Injury - / ling, etc. (Sp	At home, fa	arm, street	t, factory	, office			28f. Location	Street and	d Number or	Rural F	Route Number,
	Div after Dira	Certification:	4 Homicide		build	ing, etc. <i>(Sp</i>	ecity)						City or To	wn, State)			
	Hospital Hospital Hospital Funaral	aic	29a. Certifier 1 Cert	ifying Ph	ysician: To the	e best of my	knowledge	e, death o	ccurred a	at the tim	ne, date an	d place, a	and due to the	cause(s)	and manner	as stati	ed.
	a Ho 24 h a Fu	Medical	(Check only 2 Med one)	oal Exan	niner: On the b	pasis of examiner stated.	nination an	nd/or inves	stigation,	in my or	pinion, dea	th occurr	ed at the time,	date and	place, and d	ue to th	ie cause(s)
	Division of Vital Re To the Hospital or Attending Physician: The It within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Me	29b. Signature and title of ce	tifier	1 Li	/			29c.	License	e number			29d. Date	e signed (Mo	nth, Da	y, Year)
		111	1 1-1		1 / /					-							

State

Registrar

31. Date filed (Month, Day, Year)

PATTENSON MD 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

D0057908

BOOS TALBUT ST. ST. MICHAELS IND

			For State Registrar		State o	of Maryla	•	artmen rtificat				lental Hyg	giene Reg. N 2 (105	2130	12
	Physici	an	1. Decedent's Name (First, Mid Ruth Mc									2. Date of Dea Month June	Day	2005 ^{ear}	3. Time of De 2:03p	eath M
	/Medic Examin		4a. Facility Name (If not institut			m <i>ber)</i>		4b. City,	Town, or	Location	of Death	oune		unty of Dear		
	LAGIIIII	C.	Brinton Woods	Nurs	sing &	Rehab		Syke	svil	le			Car	roll_		
	Funeral Director		5. Social Security Number 218–12–3545	6. Sex 1 □	м 2 . F	7. Age (In yr. 81	s. <i>last birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Sept 12	v. Year)	Co	hplace (State or F buntry)	Foreign
	land		Usual Residence of Decedent 10a. State 10b. Cour	ty		10c. (City, Town or Lo	cation				-			10d. Inside City	Limits
	a-f sho	ctor	Md C	arrol	.1		Sykesv	ille							1 ☐ Yes 2	No
	h with the 23a or 28	ai Director	10e. Street and Number 4859 Bushey Ro	ad				10f. Zip	Code 2178	4			10g. Citizen USA		ountry?	
920	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or Itams 23a or 28a-f show evant, I're Modical Evarill writinal be notified at	by Funerai	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	arried	Armed F	2 XNo		Was Deced If Yes, spec 1 ☐ Yes	ofy Cuba	spanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, Whit ecify: Wh		
21215-0036	C * 0	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	nest grade	completed)	1-4or 5+)	life.	kind of wo DO NOT us	rk doné d se retired	<i>luring</i> mos	st of work	ing		of Business	Industry	
121	filed within Hygiene. other than " ant, the Me		17. Father's Name (First, Middle	e /ast)			C	ashie	r	18 Moth	er's Nam	e (First, Middle,	groce			
Maryland	2 should be filed within and Mental Hygiene. I la marked other than raumatic evant, the M	To Be	Clarence		.s							Lenora				
lary	or ear ear		19a. Informant's Name/Relation					-				al Route Numbe				
	of Health of Health litam 27		Barbara A. Sh	iffle	ett (d		r) 159 . Place of Dispo			berty		., Sykes			21784 Town, State	
altimore,	0 0		1 X Burial 2 ☐ Crematio 1 4 ☐ Donation 5 ☐ Other		emoval from	State L	ake Vie	Mem	ther plac Oria	1	6-25		Sykes	-		
Balti	permit. Page Department Important: Il any injury o	21. Signature of Funeral Servi	4	2. Name an			наз	ight Fun			& Chapel					
	Physician		23a. Part1. Enter the disease, shock, or heart failure. L' Immediate Cause (Final disease or condition resulting in death)	or complicient only on	ations that e cause on	caused the de each line.		er the mod	e of dyin		cardiac				Approximate Interval Betwe Onset and De	
	/Medical Examiner				Due to	(or as a cons	equence of):)						0	
۳	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	1 b	Due to	(or as a cons	equence of):									
8760,	cate be executed obysician and the burial-transit	cai Examine	that initiated events resulting in death) Last	C	Due to	(or as a cons	equence of):									
O. Box 6	ie death certifii the attending p hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23	1 Live	utcome of preg birth 2 □ Fe nant at time o	etal death 3	Ectopic pi Other (sp					23d.	. Date of de Month	ivery Day Yea	ar
0	puires that the signed by ald be detact		Part II. Other significant cond	itions con	. /		resulting in the u	nderlying o	ause giv	en in Part I	l. 		obacco use		o the cause of dea obably 4 DUnk	
Records,	0 0	Completed by										24a. Was autop perfo 1 \(\sum \text{Yes} \)		4b. Were at prior to death?	utopsy findings ava completion of cause	ailable se of
Vital	Phyaician: The this certificate ral director, pag	Be	25. Was case referred to med examiner?		ospital:				Oth	000		h (Check only o				
of	this ald di	on: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pen		28a. Date		ER/Outpatie	f 2	8c. Injun Wor	4 p S(N) / at </td <td></td> <td>ome 5 ☐ Resid 28d. Describe h</td> <td></td> <td></td> <td>cify)</td> <td></td>		ome 5 ☐ Resid 28d. Describe h			cify)	
Division	To the Hospital or Attending Is within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Cou	stigation Id not be irmined	28e. Płac build	e of Injury - Al ding, etc. (Spe	t home, farm, st cify)	M reet, factory		Yes 2□	No	28f. Location (S City or Tox	Street and N vn. State)	umber or R	ural Route Numbe	II.
_	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	edical C	29a. Certifier 1 Certific (Check only 2 Medic	ying Phys al Examir	er: On the	e best of my k basis of exami	nowledge, deal	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date and pla	d manner as	s stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and vitle of cert	mer /				290	D 20	9806)		29d. Date, si	igned (Mont	h, Day, Year)	
•	6		30. Name and address of pers	on who co		use of death (II	tem 23a) (Type,	Print)	LIL	seite	Rd	1 E'ldo	esseer.	a1)	21784	
	Sta Regist	ate rar	31. Date filed (Month, Day, Ye JUN 2	ar)	32	Registrar's Sig	gnat Age	adi)		-/	,		J		01	

				For State Registrar	State o	of Ma	ryland		artment ertificate		ealth and Meath	lental F		ne . No D	05	21200
		o		Decedent's Name (First, Middle, L.	ast)							2. Date of Month				3. Time of Death
		Physici /Medio		Janice Barron M	lligan	,						June	23,	^{Day} 2005	Year	5:35 A. M
		Examir	ner	4a. Facility Name (If not institution, gi		mber)					ocation of Death			4c. Count	y of Death	
		F		Suburban Hospita 5. Social Security Number 6.	Sex	7. Age	(In yrs. las	t birthday	Beth If Under 1		If Under 24 Hrs.	8. Date of		Montg		place (State or Foreign
		Funeral Director			1□M 2XF	·····g-c	86	Yrs.		Days	Hours Min.	July	Day, Y.	1918	Sout	n Dakota
		pu 🖈		Usual Residence of Decedent 10a. State 10b. County			10c. City, 1									
		Aaryla F shor	ō	Maryland Montgome	16 x x		-									0d. Inside City Limits 1 ☐ Yes 2 No
		28a-	rect	10e. Street and Number	EL y		Kens	riigt	10f. Zip (Code			10a	. Citizen of	What Cour	
		death with the Maryland ms 23e or 28a-f show	ai D	3620 Littledale H	Road				20	0902				ited		-
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23e or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Dec Armed Fo 1Yes If Yes, Gr Year or D	orces? 2 ∏ No ve		13.	Was Decede		panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or Rican, etc.)	No-	Bla	ce - Americ ck, White, by:Whit	etc.
	Maryland 21215-0036	72 hour	Completed t	15. Decedent's E	ducation	ales.	1	6a. Dece	edent's Usual	Occupati	on ring most of work	ina	16	o. Kind of E	lusiness/Inc	dustry
	121	within ane. then "	mple	Elementary/Secondary (0-12)	College (1-4or 5+		_		retired)	ring most of work	"·g	Fe	doral	Corre	ernment
	d 2	filled y Hygie other i	e Co	17. Father's Name (First, Middle, Las	4			Secr	etary	1	8. Mother's Name	ə (First, Mide				er mment
	an	lid be fental rked c	To Be	Edward Barron							Vivian 1		,		,	
	ary	s mar s mar	 	19a. Informant's Name/Relationship	Туре, Print)			19b. Mail	ing Address (Street an	d Number or Rura		nber, C	ity or Town	, State, Zip	Code)
		and and malth m 27 her tru		Virginia Thompson	/ Daug	hter					, Sudbur					
	Baltimore,	iges 1 if ite or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [Removal from	State	Mont	gome	osition (Name matory or oth Ly	ner place)	June	-		. Location		
S	Ē	artmer artmer ortant injury		* 4 □ Donation 5 □ Other (Special Signature of Figure 1) Service Light			Cre	matc	rium,	Inc.	2003					aryland
23	Ba	Depo		> KAGled		MO 1	.353	Be	thesda	i-Che	vy Chase	Inc	350	557 W	iscon	eral Home/ sin Avenue
V.		= 1		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that o	aused to	he death. I									Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	Pneu											Onset and Death Two Days
10		/Medical Examiner		resulting in death)	Due to	(or as a	consequen	ce of):								
goleelo			-	Sequentially list conditions,	b. Due to	(or as a	consequen	ce of):								
0		uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (List 689 or in jury) that initiated events		(0.7.								
3	0,	an an	Еха	resulting in death) Last	Due to	(or as a	consequen	ce of):								-
	8760	ate be hysici the bu	dicai		_ d											
	9	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit		IF FEMALE:	23c. If yes, out	come of	pregnancy	,								
0	Вох	d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No	1☐Live b	irth 2	Fetal de	ath 3[☐Ectopic pred ☐ Other (spec						te of delive onth	ry Day Year
a	0	it the c by the tacher	hys	9 Unknown	9□ Unkn	own										
-	s, p	equires that the sen signed by th rould be detache	ру Р	Part II. Other significant conditions	contributing to de	eath but	not resultir	ıg in the ι	inderlying cau	use given	in Part I.	23e. Di	d tobac	co use con	ribute to th	e cause of death?
ξ	ord	een si ould	ted									1[Yes	2 🕅 No	3 Prob	ably 4 Dunknown
Jani	Records,	e law has b	Completed		•							24a. W	as an topsy rformed		prior to con	osy findings available inpletion of cause of
_	a	ilcian: The lav certificate has rector, page 2	e Col	OF Was seen aftered to a still								1 ☐ Yes	2 💢		death? 1 🗌 Yes	2 No
ટ્રે	Vital	Phyaician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No	Hospital:	npatient	2□FR	Outpatie	nt 3 DOA	Other	 Place of Death Nursing Hor 			6 00	at (Cassit	A
9	of	g Phy ler thi		27. Manner of Death	28a. Date		28	b. Time o		c. Injury a Work?		28d. Describ				7
	Sior	endin sath. or: Afi he fur	atio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	, Duy .	, our,	Піјату	М		s 2 No					
milligan,	Division	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	289. Place	of Injury	/ - At home (Specify)	, farm, st	reet, factory,	office		28f. Location City or 7	(Street	t and Numb tate)	er or Rura	Route Number,
5	L	spital		29a. Certifier 1 X Certifying Pl	nysician: To the	best of	my knowle	dge, deat	h occurred at	the time.	date and place.	and due to th	ie cause	e(s) and ma	nner as st	ated.
		n 24 h	Medical	(Check only 2 Medical Example)	niner: On the ba	asis of e	xamination	and/or in	vestigation, i	n my opin	ion, death occurr	ed at the tim	e, date	and place,	and due to	the cause(s)
_		To the To the Complex	Σ	29b. Signature and title of contifier					29c.	License n	umber		29d.	Date signe	d (Month, L	Day, Year)
		100	1	- Latitul	MD					0117			Jur	ie 24,	2005	5
		20	- 1	30. Name and addreg of person who Eric J. Park $M.D.$, Ro	ckville,	MD.	2085	0		
		Sta		31. Date filed (Month, Day, Year)	32. R	egistrar'	s Signature	1								
		Registr		JUN	2 8 200		()		· La	A a						
	DH	MH 17 Rev 1/20	001			1	O.E.	RIGINI	1							
							U 1		n days							

_		•	For State Registrer		Sta	ate of M	arylan		partmer ertifica				ental Hy		005	213	304
	Physici	an	1. Decedent's Name			M							2. Date of De Month		2005 Year		of Death
	/Medic	al	LEO 4a, Facility Name (I		nry	Moor			4h Cih	Town or	r Location	of Death	June	<u> </u>	County of Deat		:04 p ^y
	Examin	er	Upper Ches							l Air	Location	OI Death		40.	Harford	"	
	Funeral		5. Social Security N	lumber	6. Sex	7. Ag	ge (In yrs.	last birthda	y) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Bir	th Voor		nplace (State	e or Foreign
	Director		217-20-1661		1 XM 2	! 🗆 F	78	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Februar	ý 21°,	1927 Ma	ryland	
	and		Usual Residence of 10a. State	f Decedent 10b. County			10c. Cit	ty, Town or	Location							10d. Inside	City Limits
	Maryland -f show lied at	JO.	MD		ford				t Hill								es 2 No
	with the Maryland a or 28e-f show	rec	10e. Street and Nu		,					p Code				10g. Cit	izen of What Co		
	death with the ms 23e or 28e	Funeral Director	1311 W	est Jar	rettsv	/ille F	Road			2105	50			L	J.S.A.		
		ner	11. Marital Status		Ar	as Decedent med Forces?	?	J.S. 1	3. Was Dece	dent of H	lispanic Ori	igin? (Spe n, Puerto f	cify Yes or No Rican, etc.))-	14. Race - Ame Black, White		
36	hours alter tural', or Ite	by Fu	1 Never Marr		ed 14	Yes 2 Tes, Give ear or Dates:	No 147	7-150	1 🗆 Yes		Specify:					White	
1804 215-0036	72 hours "natural", dical Ex	edt		15. Decedent	s Education			16a. De	cedent's Usi	al Occup	ation			16b. K	ind of Business/		
215	.5 - 3	piet	(Spec	cify only highes andary (0-12)	T	pleted) ollege (1-4or	5+)	- (G.	ve kind of w b. DO NOT i	ork done i ise retired	during mos d)	st of workir	ng				
21	filed withii Hygiene. other than	Completed	7			3 ()		E1	.ectri	cian					deral G	overn	nent
pu	₩ a b w	Be	17. Father's Name		.ast)	M2							(First, Middle	, Maiden			
りる	d 2 should th and Men 7 is marke traumatic	ဥ	Richa:		in (Tyna Pi	Moone	≅y	10h M	ailing Address	s (Stroot		Lilli		or City	E11 or Town, State, 2		
Ma	od 2 lth a 27 is		Miriam I											_	st Hill		21050
$6/25/\delta 5$ altimore, Maryland	iges 1 and 2 at of Health if item 27 i		20a. Method of Dis	position				Place of Dis	sposition (Na rematory or	me of	4		ate		ocation - City or		
OE	Page tent o int: if iry or		1 □XBurial 2 `4 □ Donation	☐ Cremation 5 ☐ Other (Sp		al from State			of Fait			6/29/0	D5	Bal	timore, M	D	
, alti	permit. Page Department Importent: I any injury o		21. Signature of Fu	uneral Service I	icenses	William	G. Da		22. Name a	nd Addre	ss of Facili	ty Ruck	: Towson	Fune	ral Home,	Inc.	
8	207 2 2		M	h					1050 Yo	ck Rd	., Tou	son, M	D 21204	+			
24				art failure. List	complication only one cau	ise on each I	ine.		enter the mo	de of dyin						Approxin Interval E Onset an	Between
0	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	_ a		0		al	INT		770	o asi			Imm	edidl
	Examiner					Due to (dr as	OV C	quence or):	U V.	10 N	4	dis	0 asi	2		WX	novon
		Jer	Sequentially list contains to a cause. Enter Under Cause (Disease or	onditions,	b. —	Due to for as	a consec	чинтсе от).	000		1	00, =					
35	nd	Examiner	that initiated event	S	c												
181	be executed sician and burial-transit		resulting in death)	Last		Due to (or as	s a consec	quence of):									
' 00	cate b	dicai			d												
M8003 P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was deceder	nt prograpt	23c. If	yes, outcome	e of pregna	ancy							23d. Date of del	verv	
80	death a atter d for u	iciar	in the past 12	2 months?	4	□Live birth □Pregnant a			3 □Ectopic ; 5 □ Other (s		/				Month	Day	Year
₹0.	at the by the tache	hys	9 🗆 Unknowr		91	Unknown											
ທົ	res that the de igned by the a be detached t	by	Part II. Other signi	ificant condition		-			, ,			i. 1 SEN	_		use contribute to		
Mouney of Vital Record	w require been sig should b	Completed				(10000	1100			0/11	70	1 901	112	Yes 2	□No 3□Pr	obably 4	Unknown
Sec.	e law has b	mple		1PHO		f .		. 0 .					24a. Was		24b. Were au prior to death?	topsy finding completion of	gs available of cause of
Ø y				RHYTI	NIM	(C+	TRD	140)				1 ☐ Yes	2 No		2 🗆 No	
Modne f Vital Rec	ysician: is certific director,	o Be	25. Was case refe examiner? 1 ☐ Yes 2♥	irred to medical No	Hospit	al: 1 □ Inpati	ient 2D	R/Outpa	tient 3 🗆 D	OA Oth	05		(Check only		6 □Other (Spe	2.6.1	
2.4	등 글 등	n: To	27. Manner of Dea	ith	28	a. Date of Inju		28b. Time	e of	28c. Injur Wor			28d. Describe			лу)	
Ö	ttending F death. :tor: After the funer	atio	1 Natural 2 ☐ Accident	5 □ Pendin investig	ation	(World), De	ay rear)	Inju	M		Yes 2	No					
Vision	or Attendation of Director:	Certification:	3 🗌 Suicide 4 🗋 Homicide	6 🗌 Could r determ		e. Place of In building, e	njury - At h	nome, farm,	street, facto	ry, office		2	28f. Location (City or To		nd Number or Ru e)	ral Route N	umber,
Ϋ́Ω	ospital or A hours after unerel Dire ly filled in b	Cel		<i></i>													
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one)	2 Medical	Exeminer: (i: To the best On the basis on Ind manner s	of examina	owledge, de ation and/o	eath occurre r investigatio	at the tir n, in my o	me, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	date and) and manner as d place, and due	stated. to the caus	Θ(s)
_	To the He within 24 To the Fu	Me	29b. Signature and	d title of certifier					25	c. Licens	e number			29d. Da	te signed (Mont	n, Day, Year	-}
	->-0		> Zu	ary	EL	raig	M			DO	054	273	3		CO/27/05 SVILLE,MD 21084		
	KX		30. Name and add			ted cause of	death (Ite	m 23a) (Ty	oe, Print)	e. /	IF V	20			-0111	110	71081
	0,	1		ECRA		J 17	IIBW	JAR	KEIL	3016	-L /	7	JARRI	= [7	JVILLE	CINI	
	Sta Regist	ate rar	31. Date filed (Moi	JUN 2	8 200	32. R	irar s Sign	di ure	Goad								

			State of Maryland / Department	artment of Health and Mental Hyg	9
	q		Decedent's Name (First, Middle, Last)	2. Date of Dea	th 3. Time of Death
	Physici /Medio		Marie W. Miles	Month June 2	3, 2005 4:10 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Ivy Hall Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Middle River If Under 1 Year If Under 24 Hrs. 8 Date of Birth	Baltimore
	Funeral Director		217-26-0191 1 M 2 M F 101 Yrs.	Months Days Hours Min. 8 Date of Birth Month, Days 8 18 1	(Year) 9. Birthplace (State or Foreign Country) Maryland
	σ		Usual Residence of Decedent		naryianu
	show	<u> </u>	10a. State 10b. County 10c. City, Town or Lo Maryland Baltimore Baltim		10d. Inside City Limits
	the N	Director	Raryland Baltimore Baltim		1 ☐ Yes 2 No
	3a or		44 Stabilizer Drive		0g. Citizen of What Country?
	death ms 2	Funeral		21220 Was Decedent of Hispanic Origin? (Specify Yes or Nof Yes, specify Cuban, Mexican, Puerto Rican, etc.)	U.S.A. 14. Race - American Indian,
9	or its	Fu	1 Never Married 2 Marned 1 Yes 2 ANO	f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🌣 No Specify:	Black, White, etc.
Ö	hours tural',	q pá	3 XWidowed 4 □ Divorced Year or Dates:		Specify: White
7.	filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or items 23a or 28a-1 show ant, the Medical Eversities must be notified at	Completed by	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) """ Unknown	Server	resturant
g	al Hy d othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, I	Maiden Sumame)
yla	ould to	9	Ernest Rhorman	Elisa Merker	
Maryland 21215-0036	d 2 sh h and 7 is n traum			g Address (Street and Number or Rural Route Number	
	is 1 and 2 of Health a litam 27 is other treu		20a. Method of Disposition 20b. Place of Dispo	Box Hill South Parkway Abi	20c. Location - City or Town, State
ē	Pages ent of nt: if if		1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	natory or other place)	Baltimore, Maryland
Baltimore,	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examinat must be multipled at once.			Name and Address of Facility Miller-Dipp	
<u>~</u>	Department Department		Toka Cana	415 Belair Road Baltimore	, Maryland 21206
			2a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory arre	est, Approximate
	Physician	i n	Immediate Cause (Final disease or condition resulting in death)	your cardin in lar	ct - Seet and Death
	/Medical Examiner		Due to (A as a consequence of):	yourshir wifer the se	101
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Clisease or injury	e of ent a se	yens,
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.		
o Î	ate be executed thysician and the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d		
9 ×	leath certifica attending ph I for use as t	/Me	IFFEMALE:		
Вох	that the death cer ed by the attendir detached for use	clan	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
P. O.	the d by the ached	hysl	1 Yes 2 Do 4 Pregnant at time of death 5 D	Cure (specify)	
	res that signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the un	ndertying cause given in Part I. 23e. Did tob	acco use cont e to the cause of death?
ğ	w require been sig should b	ted t	Julie will dise	1 □ Ye	s 2 2 0 3 ☐ Probably 4 ☐ Unknown
Vital Records,	has be	Completed	- Cuntid arters	LIN & Mas ar autops	
E	ystctan: The is certificate hadirector, page	Con		DV / perform	death?
<u> </u>	itcian: Th certificate rector, pag	Be	25. Was case referred to predical examiner?	26. Place of Death Check only one	9)
ot	문 는 F	1: To	27. Manner of ath 28a. Date of Injury 28b. Time of	28c. Injury at 28d. Describe ho	
ion	ttending I death. ctor: After / the funer	atlor	1 ural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No	w injury occurred
Division of	r Atte er deg recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office 28f. Location (Str. City or Town,	eet and Number or Rural Route Number,
	ital or A				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 2 ☐ Madical Examinar: On the basis of examination and/or inv	occurred at the time, date and place, and due to the ca estigation, in my opinion, death occurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	ithin ithin on the omple	Mec	one) and manner stated. 29b. Signature and title of certifier		d. Date signed (Month, Day, Year)
	- s - ō		Malun Co.	008358	
	h		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print) Canz 11 12 FO.	ep Roan
	9		GRACINV. PATRICIO	BACT HARRY	CARID 21234
• •	Sta Registr	_	31. Date filed (Month, Day, Year) JUN 2 8 2005 32. Registrar's Signature		
	· riegion		LOUS RECEIVED SO		

		,	1 - For State Registrar	State of Marylar		ent of Healt ate of Dea		lygiene Reg. N2 0 0	5 21306
	² 0		Decedent's Name (First, Middle, Last)				2. Date of	Death	3. Time of Death
	Physici /Medic	al	Claudia		Zabeti		ille Jun	e 28, 20	
1	Examin	er	4a. Facility Name (If not institution, give s	1		ty, Town, or Locati	5 4 5	4c. County of	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday If Un		der 24 Hrs. 8. Date of	Birth 9	. Birthplace (State or Foreign
	Director		243-01-1224	M 2RF 102	Yrs. Month	S Days Hou		Day, Year) 28,1903	Vivginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	Mary P-f sh	tor	Maryland Prince	Georges (Clintor	١			1 ☐ Yes 2 No
	th the	Director	10e. Street and Number			Zip Code		10g. Citizen of Wh	at Country?
	ath w		8309 Deers-			2073	_	USF	4
	ler de	Funerai	11. Marital Status 1 □ Never Married 2 □ Married	 Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 Tho 	J.S. 13. Was De If Yes, s	cedent of Hispanic pecify Cuban, Mex	o Origin? (Specify Yes or kican, Puerto Rican, etc.)	No- 14. Race - Black,	American Indian, White, etc.
920	72 hours after death with the Maryland natural', or terms 23a or 28a-f show Jisal Estrollant and be multifued at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Spec	cify:	Specify:	Black
21215-0036	be filed within 72 hours after death with the Marylan hat Hyglene. Id other than "natural", or Items 23a or 28a-f show event, if a Medical Exterior at most be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent's U	work done during i	most of working	16b. Kind of Busi	ness/Industry
121	within ene. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	use retired)	Ker	01110	HOME
	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)		Howk		other's Name (First, Midd	dle, Maiden Surname)	
Maryland	should be filed and Mental Hygis marked othar imatic evant, to	To Be	Stephen	Lee B	sland		Mary		eed
lary	2 should and Men Is marke		19a. Informant's Name/Relationship (Ty)	pe, Print) niece	19b. Mailing Addre	ess (Street and Nu	mber or Rural Route Nur.	nber, City or Town, St	ate, Zip Code)
	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		Paulette Bland			eerstil		MIN NOTA	
) Jor	0 = 5		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ R	sinoval iroth State	Place of Disposition (/ cemetery, crematory of		Date	20c. Location - Ci	
Baltimore,			 '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		OSE A WN	and Address of Fa	4	Hand al Hon	ver ce. Va.
B	permit. Departm Imports any Inju		Probest B	Balen Hr.		Hawk		al For	lackstone Va.
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea	ath. Do not enter the m	ode of dying, such	as cardiac or respiratory		Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	DECUR	WTIA				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):				
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):				
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of nice) that initiated events						
90,	sate be executed obysician and the burial-transit	i Ex	resulting in death) Last	Due to (or as a conse	quence of):				
98760	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dicai							
Box 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn				23d. Date of	of delivery
	the atte	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown				Month	
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions con						
ds,	signe d be c	d by	AN ELUIA	mbating to death but not re	salling in the andenyin	g cause given in Pa			ute to the cause of death?
S	w requir been s should	lete	MURAIUN				24a. W	as an 24h We	re autopsy findings available
Vital Records,	The lav	Completed	<i>//</i>				au	topsy prio	or to completion of cause of
ital		BeC	25. Was case referred to medical examiner?			26. P	lace of Death Check onl		Tes 2 No
of V	Physician: rthis certific ral director,	၉	1 ☐ Yes 2 🗷 No				Nursing Home 5 Re		he to Mill A
uc		tion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2		e how injury occurred	0
Division	r Attandii er death. rector: A by the fu	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec				(Street and Number	or Rural Route Number,
ā	tal or A s after al Direct ed in by	Certification:	4 Homicide	building, etc. (Speci	ity)	•	City or 1	Town, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date on, in my opinion,	e and place, and due to the death occurred at the time	ne cause(s) and mann e, date and place, and	er as stated. d due to the cause(s)
	To thi within To the comple	Me	29b. Signature and title of certifier	0-/		29c. License numb	per	29d. Date signed (/	Month, Day, Year)
			M.Cul	PHYS	VICIAW !	00054	547	6/28	7/05
	5		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Print)		Suite	2 350	20707
			31. Date filed (Month, Day, Year)	CYITTE	rden 73	so van	Dusen R.	d. Lau-	rel, md.
	Sta Registr		11N 9 8 2005	32. Registrar's Sign	Apostu				

			For State	State of M	/laryland / [Department of F Certificate of I			ene 3. N 2 0 0 5	21207
			Registrar 1. Decedent's Name (First, Midd	lle, Last)		Certificate of	Dealii	Reg 2. Date of Death	NE UUJ	3. Time of Death
	Physici /Medic		Bertha	NEWE	BORN			June :	22 2005	22:47 M
	Examir		4a. Facility Name (If not institution	=	r)		r Location of Death		4c. County of Death	
			1049 N. Carol: 5. Social Security Number		Age (In yrs. last bir		altimore If Under 24 Hrs.	9. Date of Righ	NA	
	Funeral Director		217-12-0121	t □ M 2 🔀 F		Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 8-23-0	rear) Cou	place (State or Foreign htry) N.C.
	p ,		Usual Residence of Decedent 10a, State 10b, Count		100 City To					
	the Marylan 28a-f show	Į.			10c. City, Town					10d. Inside City Limits 1 Yes 2 No
	the A	rect	Md . 10e. Street and Number	NA		Baltimore 10f. Zip Code		100	g. Citizen of What Cou	
	h with	al Di	1049 N. Card	oline Stree	t	212	205		USA	,
	ems ?	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If You Give		1☐Yes 2☐No	Specify:	,	12.00	lack
215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examulator Indiffed at	ted t	15. Decede	nt's Education		Decedent's Usual Occup	ation	16	6b. Kind of Business/In	
218	within 7 ene. than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4o	r5+)	(Give kind of work done of life. DO NOT use retired	during most of worki	ng		
121	Hygien Hygien othar th		5th grade 17. Father's Name (First, Middle	/ anti		Homemaker	40 Markada Nasa		Own Home	
Maryland	d d d	To Be	Tope	, Last)	Harris	=	Fannie	(First, Middle, Ma	uden Sumame) Harris	_
aryl	should and Men Is marke	Ě	19a. Informant's Name/Relation	ship (Type, Print)		. Mailing Address (Street				
	1 and 2 Health a tam 27 Is		Herbert Newbor	n Son		701 N. Ceci	l Ave., M	illersvi	lle, Md.	21108
ore			20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from Stat	cometer	Disposition (Name of y, crematory or other place	:e)	Pate 20	Oc. Location - City or To	own, State
altimore,			° 4 ☐Donation 5 ☐ Other (21. Signature of Funeral Service	·	Cedai	Hill Cem. 22. Name and Addres	6-29			el Co., Md.
Ba	permit. Departr Importa any inji		\$) 0 al	147	حبيب	March F.H			more, Md. North Ave.	21202
			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that cause t only one cause on each	ed the death. Do r			r respiratory arrest	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	1 , 1	CATION				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence	of):				
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	CEYLD FA		AV Acc	DENI		•
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1 .						
90,	e exercian ar urial-t	I Ex	resulting in death) Last	Due to (or a	is a consequence	of):				
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical		d						
Box (eath certifi attending I for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of delive	∍ry
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death at time of death	3 ⊟Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
P.0	res that the de signed by the a be detached f	Phy	9 Unknown Part II. Other significant condit			Managed discount of the second	and David	OO- Didasha		4 1 00
	signe d be d	d by	hyperter	•	but not resulting in	i the underlying cause give	en in Mart I.		cco use contribute to the	
of Vital Records,	w requir s been si should	Completed by						24a. Was an	24b. Were auto	psy findings available
Re	The lay	omo						autopsy performe 1 Yes 2	ed? death?	mpletion of cause of
/ita	sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death			
of	Physi this c	1º	1 ☐ Yes 2 ☐ No 27. Manner of Death		tient 2 ER/Ou		4 (Nuising Hor	ne 5 Residence 28d. Describe how	ce 6 Other (Specif	y)
On	nding th. : After s fune	tlon	1 Natural 5 ☐ Pendi	28a. Date of In (Month, C	Day Year)	njury Worl	Yes 2□No	od. Describe now	пцигу осситва	
Division	r Attar er dea ractor by the	tifica	3 ☐ Suicide 6 ☐ Could	mined 289. Place of I	njury - At home, fa etc. (Specify)	rm, street, factory, office	4	28f. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,
Ö	ital or irs after ral Dii	Cer								
	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical Certification:	29a. Certifier 1 Certifyi (Check only 2 Medice one)	ng Physicien: To the best Exeminer: On the basis and manner:	of examination and	, death occurred at the tim d/or investigation, in my of	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Me	29b. Signature and title of certific			29c. License	e number	29d	I. Date signed (Month,	Day, Year)
	1		▶ Vuonu	mmo		23.	5102	15,	June 27 2005	
			30. Name and address of person	who completed cause of	death (Item 23a) (Type, Print)	1	- Mass	ylano 2	12/11/
el.	Sta	ate.	31. Date filed (Month, Day, Year		No.JCHav	les strut	BAITIMO	a min	July V	
	Registi			8 2005		bracks				

		State of Maryland / Dep	artment of Health and	Mental Hygien	_
al	4a. Facility Name (If not institution, give st			2. Date of Death Month D UNC 2	2005 3. Time of Death 2005 7.55 AM altimore
	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign Country) WestVirginia
irector	10a. State 10b. County MD Baltim 10e. Street and Number			10g. C	10d. Inside City Limits 1 □ Yes 2 ▼No Citizen of What Country?
Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	21221 Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 ⊋No Specify:	DS Specify Yes or No- to Rican, etc.)	A 14. Race - American Indian, Black, White, etc. SpecifyWhite
	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) 16a. Dece (Give life.	e kind of work done during most of wo DO NOT use retired)	rking	Kind of Business/Industry n home
To Be C	17. Father's Name (First, Middle, Last) Wardy Edward		Sara	h Wilfong	
	20a. Method of Disposition	20b. Place of Disponentery, cre	osition (Name of	Date 20c.	ore MD Location - City or Town, State . George WV
	11-1			ConnellyFure. Balting or respiratory arrest,	neralHomeofEssex Nore MD 21221 Approximate Approximate Interval Between
	disease or condition resulting in death)	Due to (or as a consequence of):	afe Renal	Disa	Onset and Death
cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
nysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 3			23d. Date of delivery Month Day Year
by	Part II. Other significant conditions con	inbuting to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	
0	25. Was case referred to medical		26. Place of De	autopsy performed? 1 ☐ Yes 2 ☑ N	
၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Impatient 2 ER/Outpatie	The second secon	Home 5 Residence 28d. Describe how in	
	4 Homicide determined 29a. Certifier 1 Certifying Phys	building, etc. (Specify) ician: To the best of my knowledge, dea	th occurred at the time, date and plac	City or Town, Sta	(s) and manner as stated.
Medic	29b. Signature and title of certifier	and manner stated. Hence the basis of examination and/or in and manner stated.	29c. License number	29d. C	Date signed (Month, Day, Year)
	edical Certification: To Be Completed by Physiclan/Medical Examiner	1. Decedent's Name (First, Middle, Last) Ada G. Nestor 4a. Facility Name (If not institution, give st Genesis Loch Ra 5. Social Security Number 6. Sex 232 44 8058 Usual Residence of Decedent 10a. State 10b. County MD Baltim 10e. Street and Number 125 Riverside 1. Marital Status 1 Never Marmed 2 Married 3 Widowed 4 Disposition 17. Father's Name (First, Middle, Last) Wardy Edward 19a. Informant's Name/Relationship (Typ) PAtricia Nestor 20a. Method of Disposition 1 XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser 23a. Part 1. Enter the disease, or compile shock, or heart failure. List gold in mediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions continues that initiated events resulting in death) 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural Significant conditions continues that initiated events resulting in death) 25. Was case referred to medical examiner? 26. Could not be determined	State of Maryland / Dep State State of Maryland / Dep State State Ce	State of Maryland / Department of Health and Certificate of Death 1. Decedent's Name (First, Middle, Last) Ada G. Nestor 4. City, Town, or Location of Death Ada G. Nestor S. Social Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 2. Security Number 3. Security Number 2. Security Number 2. Security Number 3. Security Number 3. Security Number 1.	The September Certificate of Death Rep.

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylan	•	artment of Hertificate of D		and Mental H		2005	21309
			Decedent's Name (First, Middle	, Last)					2. Date of	Death		3. Time of Death
	Physicia /Medic		Lawrence	0s	borne				Jun 1		04 2005	7:50 AM
	Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of	of Death		4c. County of Deat	
			Heartland Heal	th Care			Hyattsvi				Prince G	eorge
	Funeral Director		5. Social Security Number 578–34–0398	6. Sex 1 M 2□ F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Min. (Month, March	Birth Day Yea 21,	9. Birth 1929 Was	nplace (State or Foreign unity) hington DC
	P		Usual Residence of Decedent		40- 03	7						
	anyla shov	_	10a. State 10b. County			y, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	Director	District of Col	umbia	Wa	shingt	T			40-	Citizen of What Co	21
	with Sa or	급	3333 Wisconsin	Avenue N	orth Wes	st	10f. Zip Code 20003				ited Stat	1
	death ma 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. 1	Was Decedent of His	spanic Ori	gin? (Specify Yes or	No-	14. Race - Ame	
36	72 hours after death with the Maryland Inatural; or Itema 23a or 28a-f show Jisal Evan Inst must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🏋 Divorced	Armed F ed 1 Tyes If Yes, G Year or	≵ [X]No ive		f Yes, specify Cubar 1 ☐ Yes 2 ☐ No	Specify:	, Puèrto Rican, etc.)		Black, White	
21215-0036	2 hou	edit	15. Decedent	's Education			dent's Usual Occupa	tion		16b.	. Kind of Business/	
715	within 72 ene. than "n	Completed	(Specify only highes Elementary/Secondary (0-12)	1) (1-4or 5+)	(Give	kind of work done di DO NOT use retired)	urina mos	of working			
21	e filed within al Hygiene. I other than " vant, Ille We	E O	Eleventh	College	(1-401 5+)	Did N	lot Work			l	None	
nd	be file ital Hy d oth	Be (17. Father's Name (First, Middle, I	Last)					r's Name (First, Mid	dle, Maid	len Sumame)	
yla	2 should be and Mental is marked aumatic ev	2	Lawrence Osbor						i Green			
, Maryland	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. It health and Mental Hygiene titem "natural", or Itema 23a or 28a-1 show tiem 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic evant, the Medical Exerciting mark to colline and		19a. Informant's Name/Relationsl Selma E. Provid		ce				or or Rural Route Nu W. Apt 3A			
ore	es 1 a of He fiterr r oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	2 Pomoval from		Place of Dispo	sition (Name of natory or other place)	Date	20c.	Location - City or	Town, State
Ĕ	Pag ment ant: i		`4 □Donation 5 □Other (S)		Riv	verdale			6/27/05		verdale,	
Baltimore,	permit. Pages. Department of himportant: if ite any injury or of once.		21. Signature of Funeral Service	Licensee	Moll				Robert G Rd SE, Wa			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not ent	er the mode of dying	, such as	cardiac or respirator	y arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Athe	rosclero	otic He	eart Disea	ıse				Onset and Death
	/Medical Examiner		resulting in death)	-	(or as a conseq							
ь	LAdilinici	_	Sequentially list conditions,	b. — Due te	/22 22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2							,
	ted nsit	nIne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	quence or):						
	al-trai	Examln	that initiated events resulting in death) Last	c. Due to	(or as a conseq	(uence of):			<u> </u>			
68760,	icate be executed physician and s the burial-transit	dical		d								
	tificat ig phy as th			V								
Вох	death certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pregnancy				23d. Date of deli	
	The law requires that the death certif the has been signed by the attending page 2 should be delached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of d		Other (specify)			-	Month	Day Year
P.0	that the ed by detac		Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause give	n in Part I	23e. D	id tobacc	o use contribute to	the cause of death?
Records,	uires tha signed d be det	d by	Cerebrovascu	_		-	, ,					obably 4 Dunknown
Sor	w requir been si should	lete	Ventral Hern						24a. V			topsy findings available
Re	The lav	Completed							a	utopsy erformed	prior to death?	ompletion of cause of
Vital		C	25. Was case referred to medical				·	26 Place	of Death (Check or	_A	No 1 ∐ Yes	2 No
Ĭ.	Physician: this certific ral director,	OB	examiner? 1X Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Othe		rsing Home 5 R		6 ∏Other (Spec	eify)
οl		n; T	27. Manner of Death	28a. Date		28b. Time o	28c. Injury Work	at 2	28d. Descri	be how in	jury occurred	,,,
Š	Attendin death. ctor: Af y the fur	atlc	1 Natural 5 Pendin 2 Accident investig	ation	, _u, , ,u,,	qury		es 2 🗆	No			
Division	after de Directe	Certification;	3 Suicide 6 Could r 4 Homicide determ	ined 289. Plac	e of Injury - At he ding, etc. (Specif		eet, factory, office			n (Street Town, St	and Number or Ru ate)	ral Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	edlcal C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	examiner: On the	e best of my kno basis of examina nner stated.	owledge, death ation and/or in	n occurred at the time vestigation, in my op	e, date an inion, dea	d place, and due to th occurred at the tir	he cause ne, date a	r(s) and manner as and place, and due	stated. to the cause(s)
	o the inthin o the omple	Mec	29b. Signature and title of certifier				29c. License	number		29d. I	Date signed (Month	i, Day, Year)
	⊢ s ⊢ ō		1/11	1. Phila.	(Sw	10	7 01	050	776	1	6/24/1	5
			30. Name and address of person	who completed car	use of death (Iter	п 23a) (Type.	Print)	70		0	/	
			1160 VANNU	17 ST N	15 421	3 1	MEHEN.	217	n, O.	C.	2001	7
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 8	2005	Registrar's Signa	sture Ap	ede	-	776 n, o			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June Theodore L. Ordak 2005 5:35 P. M /Medical 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel ff Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 24, 1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 ☐ F Mary1and 88 216 10 1249 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23s or 28s-f show the Midical Examiner must be notified at 1 XYes 2 No Maryland Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5301 Pennington Avenue 21226 U.S. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 XYes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) Coflege (1-4or 5+) Attendant / Mechanic Gas Station 12th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be fits pertment of Health and Mental Hyportant: If Item 27 is marked oth y Injury or other traumatic eventy. Be (not available) 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5301 Pennington Avenue Betty Ordak / Wife Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If eny Injury or Bayview Crematory 6/25/2005 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 amerou Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Onset and Death Immediate Cause (Final **Physician** ARRION Y OPATCET resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ed by the attending physicien detached for use as the buría Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part ff. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy rmed? 2. No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 055506 120 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Ritchne Highway Paradine Mary land 21122 2109 tres 32. Registrar's Signature rc 31. Date filed (Month, Day, Year) State Sparte Registrar JUN 2 8

DHMH 17 Rev 1/2001

BETTY PAYNE 05-04098 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unpeni item 23.27.2a f. perite G25.77/05 TT State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar amend item #8 per fh 8846 8 2971115 attent of Death Reg. No. 2015 . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Betty Payne JŰNË 6:40P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1527 N.MILTON AVE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours 216-84-7816 4 () Yrs. Director MĎ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at YYes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e or 1527 N. Milton Ave. 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or iter any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th College (1-4or 5+) Security Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence E. Ball Amelia Connelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Green (sister) 3005 Erdman Ave. Balto. MD 21213 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State `4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart 6-22-05 Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wesley Chavis Jr. FH unter 2007 Eastern Ave. Balto. Md. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypertensive Cardiovascular Disease complicated by Hyperthermia disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Day P.O. I 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an autopsy performed? page 1 X Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square ther (Specify SCENE) 2 Yes 2 No 3 DOA 27. Manner of Death Certification: 20a Date of Injury TTD Month, Day Year) Time of hjury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 XAccident 5 Pending investigation death. 1 ☐ Yes 2 No June 15, 2005 6:30 P Subject Exposed to Hot Privironment Director 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and City or Town, State) 4 Homicide 1527 N. Milton Ave scene within 24 hours a Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME mid JUNE 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

Baltimore, Maryland 21201

Registrar

DHMH 17 Rev 1/2001

State

LING 31. Date filed (Month, Day, Year)

JUN 2 8 2005

MID

Registrar's Signature

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H		Mental Hyg	giene Reg. 2 . 0 0 5	5 2	1312
	Physici	an	1. Decedent's Name (First, Middle,				7.7	2. Date of Dea	Day Y	'ear	3. Time of Death 0 9 40 Am
	/Media	cal	Robert 4a. Facility Name (If not institution,		₹.		eddy Location of Death	JUNE	4c, County of	-	U 7. 40 AM
	Examir	ner	SINAL HOSPITAL		WADE	BALTIMO		V	70. 000	20411	
	Funeral		5. Social Security Number 6	i. Sex 7. Age	e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	h 9	Birthpla Countr	ce (State or Foreign
	Director		216-50-4680 Usual Residence of Decedent	1 X M 2 □ F	57 Yrs.			08 2			1D
	yland now		10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
	e Mar	ctor	MD NA		Balti	nore					1 Tyes 2 No
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh		. A
	eath v	Funeral	3521 Wild Che	rry Road 12. Was Decedent B	ver in U.S. 13		244	pecify Yes or No		• A •	
9	within 72 hours after death with the Maryland ene. then "netural", or Items 23s or 28s-f ehow is Modical Examiliar must be multified at	Fun	1 ☐ Never Married ★ Married	Armed Forces? d 1 ☐ Yes 2 💢 N	io	Was Decedent of H		Rican, etc.)	Black,	White, et	tc.
8	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 况 No	Specify:		Specify:		lack
Maryland 21215-0036	be filed within 72 hotal Hygiene. d other then "naturevent, I'm Meulcal	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	edent's Usual Occup e <i>kind of work done d</i> DO NOT use retired	during most of worl	king	16b. Kind of Busi Electri		ıstry
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<u> </u>	2 should be filed v and Mental Hygie is marked other t raumatic event, U	^L	Richard Predd				Lucill		0: 7 0		
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ē,	Teg Heg en the		Erika Preddy- 20a. Method of Disposition		20b. Place of Disp	Wild Ch position (Name of ematory or other place		Date Da	20c. Location - C		
altimore,			1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	□Removal from State ocify)		Ridge	6/25	/05	Pikesv	ille	e, Md
Balt	pemit, Page Department Important: If any injury of		21. Signature of Funeral Service Li	censee		22. Name and Address arch F/H					1
	40360		23a Parth. Enter the disease, or co	molications that caused	1/4 4	300 Waba	sh Ave,	Balti	more, M		21215 Approximate
L,			Isbock, or heart failure. List or immediate Cause (Final	nly one cause on each lin	10.		9,0002000	o. 100p. a.o., a.			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to for as	MONIA a consequence of):						WEEKS
5	Examiner		Sequentially list conditions.	b. ARTER	20 V FN OU. a consequence of):	S MACF	TLIVEATION	OF BTU	HAI	12	YEARS
	ed sit	ulnei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	* Due to (or as	a consequence of):						
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9	ertifica ling ph e as th		IF FEMALE:				-			- 1/	•
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 Fetal death 3	□Ectopic pregnancy			23d. Date Monti		y Day Year
o.	at the de by the a tached	hysiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	une or death 5	□ Ottlei (specily) _					
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Vital		e Co	25. Was case referred to medical				00 Plan (Pa	1 Nes	2□No 1□	Yes :	2 2 N o
	ysicia is cert directe	OB	examiner?	Hospital:	nt 2□ER/Outpatie	ent 3 DOA	er: 4 ☐ Nursing H		dence 6 □Other	(Specify)	
Division of	ding Phys h. After this funeral dir	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day			y at		now injury occurred		
<u>S</u>	uttendi death. ctor: A y the fu	catl	2 Accident investiga 3 Suicide 6 Could no	t he			Yes 2 □ No	206 Leasting (Street and Alimber	or Our	Doute Alimber
Σ	or Att after d Direct in by	Certification;	4 Homicide determin	ed 286. Place of Inju-	ury - At home, farm, s c. (Specify)	treet, factory, office		City or Tox	Street and Number vn, State)	or nurar	Addie Number,
	To the Hospital or Attending Physician: within 24 hourst alter death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying (Check only 2 Medical E)	Physician: To the best of	of my knowledge, dea	th occurred at the tir	ne, date and place	, and due to the	cause(s) and man	ner as sta	ited.
	Vithin 24 Within 24 To the Fi	Aedical	one)	taminer: On the basis of and manner sta							
	T with	Σ	29b. Signature and title of certifier	azz d		29c. Licens			29d. Date signed		
,	1		30. Name and address of person wi	o completed cause of d	eath (Item 23a) (Type	Print)	5-00) .	JUNE	XA	1003
10	L		Mulugeta Fiss	HA , NOLL	SINHI	TOSPITAL	OF PAN	TIMERE	F. ML	2	1215
	Sta	-	31. Date filed (Month, Day, Year)	32. Regist	r's Signature	boards	7		,		
	Registr	ar	eun a	0 2000	The state of the s	1					

			1 - For State Registrar	State of M	laryland / Depa	artment of Heartificate of De			giene Reg. No () ()	15 2	1313
ì	Physici		Decedent's Name (First, Middle, Ida		lae	Pr	yor	2. Date of Dea	Day	Year 2005	3. Time of Death
}	/Medic Examin		4a. Facility Name (If not institution, 3904 Hillsdal	give street and number		4b. City, Town, or Loc Baltimor	cation of Death	1.0.0.0	4c. County		
	Funeral Director		5. Social Security Number 251-24-1052 Usual Residence of Decedent	5. Sex 7. A 1 □ M 2√1 F	ige (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Months Days H	Under 24 Hrs. lours Min.	8. Date of Birt (Month, Day 11 17	h y, Year) 23	9. Birthplac Country	e (State or Foreign) C
	ne Maryland 8a-f show pilited at	Director	10a. State 10b. County MD NA		10c. City, Town or Lo	ore					Inside City Limits 1
9036	within 72 hours after death with the Maryland ane. then "natural; or items 23e or 28e-1 show the Medical Examinar must be notified at	by Funerai	10e. Street and Number 3904 HIllsdal 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces	No.	10f. Zip Code 212 Was Decedent of Hispa If Yes, specify Cuban, M 1□ Yes 2□Xio S				S A American	Indian,
land 21215-0036	be filed ital Hygi id other evant, II	To Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 7th grade 17. Father's Name (First, Middle, Lathery Addison	grade completed) College (1-40) na	(Give		ng most of work	e (First, Middle,	Yellov Maiden Sumam	. Car	Company
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumetic evone.		19a. Informant's Name/Relationshi Betty Pryor-L 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	yles-Daug B Removal from State	hter 3904 20b. Place of Disponentery, cree King Me	ng Address (Street and Hillsdal estition (Name of matory or other place) emorial Pa 2. Name and Address of larch F/H	Number or Rur Le Road ark 6/	al Route Number d, Bali Date 27/05	20c. Location -	Md City or Town	21207 , State
8760,	Cate be executed hybrician and hybrician and the burial-transit	dicai Examiner	28a. Part1. Enter the disease, or constitute of the constitute of	a	ed the death. Do not ent	er the mode of dying, su				Ar	21215 proximate terval Between nset and Death
.O. Box 6	The law requires that the death certificate be executed to the as been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	of delivery oth Da	y Year
<u>α</u>	w requires that is been signed by should be deta	by	Part II. Other significant condition	s contributing to death	but not resulting in the u	nderlying cause given ir	Part I.	23e. Did to	obacco use contr es 22 No	bute to the o	
n of Vital Records,	ysician: nis certifica director, p	on; To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 □ Inpa 28a. Date of In (Month, L		nt 3 DOA Other:	i. Place of Deat	h <i>Check o oi</i>	prmed? d 2 No 1	rior to compleath? Yes 29 or (Specify)	findings available etion of cause of No
Division	tal or Attending Pt's after death. BI Diractor: After the in by the funeral	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion at be 28e. Place of I	njury - At home, farm, str etc. <i>(Specify)</i>	M 1 ☐ Yes	2 🗆 No	28f. Location (S City or Tow	Street and Numbe vn. State)	or or Rural Ro	oute Number,
	To tha Hospital or a within 24 hours after To the Funaral Dirac completely filled in b	Medical C	29a. Certifier Certifying (Check only one)	Physician: To the best taminer: On the basis and manner:	st of my knowledge, deat of examination and/or in stated.	h occurred at the time, c vestigation, in my opinio	date and place, on, death occur	and due to the or red at the time, or	cause(s) and mar date and place, a	nner as state nd due to the	d. e cause(s)
A	Tot with Comp	M	29b. Signature and title of confier	My		29c. License nu			29d. Date signed		
U) (30. Name and address of person w	-05/4h/	death (Item 23a) (Type,	V. Belve Ja	ne Ave.	Sv.T. 2	2 Betti	more	MO
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 8 20	05 Alexander	strar's Stonature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 27 Day **Physician** Catherine 1:05pm M Pearce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2565 W. Lombard Street Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 70 Yrs Director 214-40-8607 5-5-35 N.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23s or 28e-f show injury or other traumatic event, the Medical Examinar must be notified at Y□Yes 2□No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2565 W. Lombard St. 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married X Married 1 ☐ Yes 2√2 No à Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry llth grade entary/Secondary (0-12) College (1-4or 5+) L.P.N. Summitt N.H. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 Is marked o Grady Pearce Minnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Greene Daughter 2567 W. Lombard Street, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Pittman Cemetery 5 Kenly, 1 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any ir lad March F.H. East 1101 E. North Ave. ware 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** cun (1) /Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the attending use IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 🗌 Yes 3 DOA Certification: To within 24 hours after death. To the Funeral Director: After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and tyle of certif D40854 12005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pul seber WD 301 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 8 2005 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death June Frieda C. Passerelli /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Agnes Hospita MD Balthmore 1 Year | If Under 24 Hrs. None If Under 1 Year 8. Date of Birth (Month, Day, Jan 3, Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 2**X**F Days 91 072 09 8633 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 □Yes 2 No Director MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 Dorsey Hall Drive 21042 United States Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Cherico Mary DiBiasi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Passerelli/Son 213 Worthmont Road Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gard. 6-27-2005 Marriottsville, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Man 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzeihmers disease or condition resulting in death) 15 Months Due to (or as a consequence of): neumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Myf6 Mynid Due o (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 20 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. ate of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 27. Manger of Death 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

Box

The law requires that the death certificate be executed

has been

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filled in by

within 24 hours after death To the Funaral Diractor;

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State

Medical

Physician

Funeral

Director

28a-f show

Items 23a

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al Hygiene.

and Mental I

Lepartment of Health an Important: If item 27 Is n. any injury or other

Physician

Examiner

/Medical

Pages 1 and 2 should nent of Health and Men

traumatic avant, the Medical Examiner must be notified at

be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

P18618.

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 100 Caton

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

82. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

JUN 2 8 2005

ORIGINAL

				1 - For State Registrar		State of	f Marylan		artment of H tificate of L		ind Mental		e 201	15	21318
		Physici		1. Decedent's Name (Fi	rst, Middle, L	Last)					2. Date	of Death	av	Vear	3. Time of Death
		/Medic		Dolores	Paso	-					Ju	ne o	41 2	.005	1936 M
		Examin	er	4a. Facility Name (If not	_				4b. City, Town, or Bel Air		f Death	4	c. County of Har f		
			•	Upper Ches 5. Social Security Numb	<u> </u>		7. Age (In yrs.		If Under 1 Year	If Under 2	A Hrs. 9 Date	of Righ			non (Chato or Foreign
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6		a or 2		10e. Street and Number 206 Meliss					10f. Zip Code	050		10g. C	itizen of W	hat Count S.A.	ry?
		death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	11. Marital Status	a way	12. Was Dece	dent Ever in U	.S. 13. V			in? (Specify Yes	or No-		- America	ın Indian.
	9	after o	Fun	1 Never Married	2 Married	Armed For	rces? 2. ∑t No		Was Decedent of Hi f Yes, specify Cuba		, Puèrto Rican, e	tc.)	Black	k, White, e	tc.
	93	ral', c	d by	3 √Widowed 4 □	Divorced	If Yes, Giv Year or Da	e ates:		1□Yes 2∏xNo	Specify:			Specify:	Whit	e
	5-0	72 h "natu dical	Completed	15. (Specify o	Decedent's nly highest of	Education grade completed)		16a. Deced (Give	ient's Usual Occupa kind of work done o DO NOT use retired	ation during most	of working	16b. i	Kind of Bus	siness/Indu	ustry
	121	within ane. than	mp	Elementary/Secondar	y (0-12)	College (1	-4or 5+)		Employed			R	lestur	rant	
	q	filed Hygid Sther ent,	C	17. Father's Name (First	t, Middle, La	st)		perr	Employed		r's Name (First, A				
	an	lid be lental ked c	To Be	Frank Hoop	es					Mar	y Schick				
3	Maryland 21215-0036	shou and N a mai		19a. Informant's Name/	Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	r or Rural Route	Number, City	or Town, S	State, Zip (Code)
1	Σ	and 2 salth in 27 I		Elizabeth	Hoopes	3			Cedonia .			ore, M	iary1a	and 2	1206
6/21/05	Baltimore,	jes 1 of He If Iter or oth		20a. Method of Disposit		☐Removal from 5			sition (Name of natory or other plac		Date		_ocation - (City or Tow	vn, State
9	ΕË	Pag tment tant: tant:		`4 □Donation 5 □	Other (Spe	cify)	Ва		ash. Crem	, -			rel,	-	
	Bal	permit. Pages I and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Furera	Service (fic	ensee			Name and Addres 5415 Bela						Home Inc. 21206
				23a. Part . Enter the di shock, or heart fai	sease, or co	implications that cally one cause on e	aused the deat	h. Do not ent	er the mode of dyin	g, such as	cardiac or respira	tory arrest,			Approximate
		Pnysician		Immediate Cause (Fina disease or condition		60	strice		Small In		100 miles (2.3	6.20		Approximate Interval Between Onset and Death
		/Medical Examiner		resulting in death)	-	Due to (or as a conseq	uence of):	~ I	. 1 .		1 - 11.	£.\		
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\	yu -	led lsit	Examiner	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injurthat initiated events	g v	Due to (or as a conseq	uence or);							
5		execui	xan	that initiated events resulting in death) Last		c Due to (or as a conseq	uence of);							
-	160	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	calE			d									
8		certificat Iding phy Ise as the				- 12									
Dolores	Box 68	th cert endin r use	Physician/Med	IF FEMALE: 23b. Was decedent pre		23c. If yes, out	come of pregna		Ectopic pregnancy					of deliver	
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59	Vital		e Co	25. Was case referred t	to medical					00 Diago	10	Yes 2 N		☐ Yes 2	2 □ No
9	Ē	Physician: this certific ral director,	0 8	examiner?	o medical	Hospital:	npatient 2	ER/Outpatien	t 3 DOA Othe	00	of Death (Check sing Home 5		6 □Other	r (Snecify)	
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754	Division	al or Attending P s after death. il Director: After I d in by the funera	Certification;	3 Suicide 6 4 Homicide	Could not determine	288. Place	of Injury - At hang, etc. (Specif	ome, farm, str	eet, factory, office			tion (Street a or Town, Stat		r or Rural	Route Number,
027759		To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edical C	29a. Certifier 12 (Check only 2	Certifying Medical Ex	Physician: To the aminer: On the ba	asis of examina	owledge, death	n occurred at the time restigation, in my of	ne, date and pinion, deat	d place, and due the	to the cause(s	s) and man nd place, ar	nner as sta	ted. the cause(s)
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		\wedge		30. Name and address	o per wh	no completed caus	e of death (Item	n 23a) (Type.	Print)	201 (14	nex	1,000	207
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. N2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Month **Physician** JUNE D: 20 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner VA modical enter. BALT. more no/ 4 BALtimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 23, 1951 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. **™** M 2□ F 54 215-58-0198 Director Maryland Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23s or 28s-f show 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Carroll Millers 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4914 Roller Road 21102 USA Be Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 [XYes 2 □ No 1969
If Yes, Give
Year or Dates: 1973 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lois Watts 2 Clarence Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4914 Roller Road Millers, Maryland 21102
ace of Disposition (Name of Date 20c. Location City or Carolynn Ruby, Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removel from State `4 ☐ Donation 5 ☐ Other (Specify) 5 06/25/05 Department of Important: If any injury or once. Metro Crematory Inc. Baltimore, Maryland 21. Signature of Euperal Service Libersee ²²Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** orgestive disease or condition resulting in death) /Medical Due to (dr as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner iding physician and se as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? melli 2 No 2 No dua hetes 1 ☐ Yes 1 Tyes or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ٥ 1 🗌 Yes 21 No 1 Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: atural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Diractor: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar Name

and address of perso

31. Date filed (Month, Day, Year) JUN 2

10 N

C-Reene Street BALLimore

DoneM

who completed cause of death (Item 23a) (Type, Print)

Istrar's Signature

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hortense B. Rene June 22, /Medical 4:30 am [™] 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pickersgill Towson Baltimore 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Ye Nov. 13, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1900 New Hampshire 1 M 2 K Months Hours 213-03-6000 Director 104 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ent: If Item 27 is marked other than "neturel", or Items 23e or 28e-f show ury or other treumatic event, it a Medical Examinations and intermediate. 10a. State "neturel", or Items 23e or 28e-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Baltimore 1 ☐ Yes 2 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Ave. 21204 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: þ 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Bealers Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Joseph Bellerose Georgiana Cote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita R. Gribbell / Daughter 600 Country Club Road Havre de Grace, Md. 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Importent: If Ite any injury or ot once. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Lorraine Park Cem. 6/24/05 Woodlawn, Maryland 21. Signature of Funeral Service Lice see 22. Name and Address of Facility 1050 York Road au Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sta ean. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed use as the burial-tran Due to (or as a consequence of): the attending physician hed for use as the buris Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month 4□Pregnant at time of death Year 5 Other (specify) be detached 9□ Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown certificate has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1□ Yes 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Medical Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident within 24 hours after death. To the Funerel Director: A 1 Tyes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

und

Charles St. Balto, Mr. 2120%

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2005

31. Date filed (Month, Day, Year)

JUN 2

			State of Maryland / De State of Maryland / De	partment of Health and M entificate 如 Death H	lental Hygiei Reg.	2005 21321				
	Physicia		1. Decedent's Name (First, Middle, Last) BERA VERA SARA	RICHTER	2. Date of Death Month JUNE 2	Day Year 3. Time of Death 3:30 A M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
			CALVERT MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	PRINCE FREDERIC	K 8. Date of Birth	CALVERT				
	Funeral Director		052-66-4974 1 M 2 MF 86 Yrs	Months Days Hours Min.	02/08/19	9. Birthplace (State or Foreign Country) HUNGARY				
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits				
	Maryli -f sho	tor		AKE BEACH		1 ☐ Yes 2 ☐ No				
	ith the	Olrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?				
	s 23e	Funeral Director	4811 WILLOWS ROAD 11. Marital Status 12. Was Decedent Ever in U.S.	20732 13. Was Decedent of Hispanic Origin? (Spe		UNGARY 14. Race - American Indian.				
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 271s marked other then "naturel", or Items 23e or 28e-f show or other treumatic event, the Medical Examinat must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes. Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: WHITE				
5-0	72 hc	eted	(Specify only highest grade completed)	ecedent's Usual Occupation live kind of work done during most of work		. Kind of Business/Industry				
121	e filed within al Hygiene. I other then "	Completed by	Elementary/Secondary (0-12) College (1-40r 5+)	re. DO NOT use retired) EACHER		EDUCATION				
nd 2	be filed ital Hygi id other event, I	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maid					
Maryland	should be nd Mental marked c	To		LACK EMILIA	-10 1 1 1 0	SPIEGEL				
Mai	and 2 sho ealth and m 27 is m			lailing Address (Street and Number or Rura 811 WILLOWS RUAD-CHI		20732				
ore,	of Health of Health litem 27 I		20a Method of Disposition 20b. Place of D			BEACH MD 20832 Location - City or Town, State				
Baltimore,	ment tent: fi		`4 □Donation 5 □Other (Specify) CHOLON		7/2005	CHOLON, ISRAEL				
Ball	permit. Pages Department of I Importent: If ite any Injury or of once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOI 8900 REISTERSTOWN	LEVINSON	N & BROS., INC. KESVILLE, MD 21208				
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death				
	Pnysician /Medical	i	Immediate Cause (Final disease or condition resulting in death) a	Arrhythmia		10 minutes				
	Examiner		Athanasalara		cular o	lisease				
FY	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
1	icate be executed physician and s the burial-transit	Examin	resulting in death) Last C	:						
68760,	ysician	edical	d							
	ertifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy							
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ls, P	es tha	by	Part II. Other significant conditions contributing to death but not resulting in the Endo Coyditis. N			co use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Onknown				
Records,	w requir been si should	leted	Sick Sinus Syndrome Hype		-	24b. Were autopsy findings available				
I Re	: The taw cate has	Completed	JICK STAMS SYNGSOME, TRYPE	CICVISIDE HEOVI ASPA	autopsy performed	prior to completion of cause of death?				
Vital	1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No Yes 2 No No Yes 2 No No Yes 2 No No Yes 2 No No Yes 2 No No No No No No No									
sior	ttending F death. ctor: After y the funer	catlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No						
Division	s after d sl Direct ed in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, fam building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	it and Number or Rural Route Number, Pate)				
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attecompletely filled in by the fune	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occurr	red at the time, date	and place, and due to the cause(s)				
	To t To t	Σ	29b. Signature and title of certifier C. Mana.	29c. License number D . 50653		Date signed (Month, Day, Year) - 24 - 2005				
	3		30. Name and address of person who completed cause of death (Item 23a) (T. 5851 - Deale Church ton		SURF	7NA 20751				
Ì	Sta Registr		31. Date filed (Month, Day, Year) 82. Registrar's Signature							

Division of Vital Records, P.O. Box 68760.

	_	For State Registrar		Cei	rtificate of L	eath (Re	2005	21322		
Physicia /Medic		Decedent's Name (First, Middle, La ELIZABETH	SIMPSON				2. Date of Death Month	Day Year	3. Time of Death 4:21 PM		
Examin		4a. Facility Name (If not institution, giv		altimore	4b. City, Town, or	Location of Death		4c. County of Death			
Funeral Director		5. Social Security Number 6. S 249 10 5261D	Sex 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 9	N/A 9. Birth Cou 1913 Sout	place (State or Foreign intry) The Carolin		
ith the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County	i i	10c. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
n with the	Funeral Director	10e. Street and Number 4514 PIMLICO R	OAD		10f. Zip Code 21 21	15		g. Citizen of What Cou	•		
72 hours after death with the Maryland Insturel', or Items 23a or 28a-f show dical Examinar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2√ No	spanic Origin? (Spent, Mexican, Puerto Specify:		14. Race - Amer Black, White	ican Indian, , etc.		
thin 72 hours e. an "natural", Medical Ex	Completed	X 15. Decedent's E. (Specify only highest gra	ducation rade completed) College (1-4or 5+	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of worki	ng 1	6b. Kind of Business/li	ndustry		
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2 should and Men is marka reumatic	To	BOYD PAIGE (D) 19a. Informant's Name/Relationship ((Type, Print)	1				↓			
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "any Injury or other treumatic event, the Mau once.		PEGGY WATERS (1) 20a. Method of Disposition 14 Burial 2 Cremation 3 C 4 Donation 5 Other (Special		20b. Place of Dispo cemetery, crei	PIMLICO position (Name of matory or other place MEM. PA	e) [Date 20	ORE MARY Oc. Location - City or T RBUTUS MA			
Physician /Medicate pe executed up bhysician and buysician and buysician and sas the brutal-transit	Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last									
The law requires that the death cert te has been signed by the attendin page 2 should be detached for use.	Physician/N	23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delivery Month Day Year			
w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.		cco use contribute to			
2 0 2	60						24a. Was an autopsy	24b. Were aut	oney findings available		
	Completed						perform		ompletion of cause of		
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/Medi		Emanuel	Sheard	Sr.	June 2	4 2005	1100 4	
Examir	er	4a. Facility Name (If not institution, give s	1	4b. City, Town, or Location of Death	1	4c. County of Death		
		5. Social Security Number 6. Sex	Ane Gift (0)	av) If Under 1 Year If Under 24 Hrs.	D. Data of Birth	NA		
Funeral Director			M 2□F 94 Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	ar) 👝 Cou	place (State or Foreign	
		Usual Residence of Decedent	17		3-29-19	10a)	4 Carolina	
rylan how		10a. State 10b. County	10c. City, Town or	r Location			10d. Inside City Limits	
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eath v	Funeral Director	400 Millington	Are continue	21223		U.J.A		
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urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Blac	K	
within 72 hours after death with the Maryland ane. ane. than "natural", or Items 23s or 28s-1 show is Madical Examiner must be notified at	Completed	15. Decedent's Edu		ecedent's Usual Occupation live kind of work done during most of wor	ting 16b	. Kind of Business/In		
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partitions, With year of IZINO Compositions after death with the Marylar permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be neitlified at once.	Be c	UNK now n		1.	ne (First, Middle, Maid	en Sumame)		
should and Me mark matic	5	19a. Informant's Name/Relationship (Tv.	pe. Print) 19b. M	ailing Address (Street and Number or Ru		v or Town State Zir	Code)	
Nice of the street of the stre		Cornelius E. Sheur	1 T	1 X 1/ DP.	do. frd. 21		, Code)	
Dallimore, IN permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition	20b. Place of Di	sposition (Name of crematory or other place)	Date 20c.	Location - City or To	own, State	
DallIIIIOTE Dermit. Pages 1 a Department of He mportant: If item any injury or oth		1 Burial 2 □ Cremation 3 □ R 3 □ Other (Specify)	emoval from State	un Cen. July	2 200- B	16 /N		
Dalti Permit. Departir Importa any inju		21. Signature of Funeral Service License	90	22. Name and Address of Facility	2, 2005 B	win P.	4.	
0 82589		Carlon C. To	Jonfang	22. Name and Address of Facility artion C. Dongless 1701 Mc Cullo L	Ballo.	1. 2/21	7	
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/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
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VICION: The icion: The certificate rector, pag	e Cc	25. Was case referred to medical			1 □ Yes 2 💢		2 No	
	0	examiner?	lospital: 1 Inpatient 2 ER/Outpa	Othor	th (Check only one)	6 DOther (Specific	ul.	
g Phye ter this neral di	n: T	27. Manner of Death	28a. Date of Injury 28b. Time (Month, Day Year) Injur	e of 28c. Injury at	me 5 🔀 Residence 6 🗆 Other (Specify) 28d. Describe how injury occurred			
Attending r death. sctor: After by the fune	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(MONON, Day Year)	M 1 Yes 2 No				
LIVISION I or Attending after death. Director: After tin by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St.	and Number or Rura	l Route Number,	
urs af oral D	0							
To the Hospital or Attanding Is within 24 hours after death. To the Funeral Director: Atter completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	ner: On the basis of examination and/or	eath occurred at the time, date and place r investigation, in my opinion, death occu	and due to the cause rred at the time, date a	(s) and manner as si and place, and due to	ated. the cause(s)	
To the within 2 To the complet	Med	Unity	and manner stated.					
F 3 F 8		Dans.	7	REC DOD	τ.	/- A 77	7000	
		30. Name and address of person who co	mpleted cause of death (Item 23a) (Tv	pe. Print)	,	re ct	C002	
(6)	1	David Riedel 6	00 N Wolfe ST	29c. License number RES-000 De. Print) Tohns Hopkins Ma	osoitel Be	Himore m	0 21287	
St	ate	31. Date filed (Mog to Ray 2 ear) 200	3 Registrar's Signature	P. M.				
Regist	rar	W 6 200	Miller D. A.	DEAEA.				

/Medi	ian	Landon		J.	Sa	antoni					2. Date of I Month JUNE	D	ay 2005	Year	3. Time of De
Exami		4a. Facility Name	(If not institutio	n, give street and num				own, or	Location of	Death	JUNE		c. County of	of Death	7:10 A
				RE HOSPITAL				SEDA]	BALTI	MORE	CO
Funeral Director		5. Social Security 213–73–3		6. Sex 7	'. Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Days 24	If Under 2 Hours	4 Hrs. Min.	8. Date of the (Month, June)	Birth Day, Year	3=	Coun	lace (State or Fo
		Usual Residence	of Decedent					24		!	ourie .	2,200)5	MD.	
ehow of at		MD.	10a. State 10b. County 10c. City, Town or Location 10b. Baltimore Essex										0d. Inside City L 1 ☐ Yes 2		
28a-	Director	10e. Street and N					10f. Zip 0	Code				10a, C	itizen of W	hat Coun	
23a o	al D	1344 Sugarwood Circle				21222						_	JSA		.,,
Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28a-f ehow eny injury or other traumatic event, I'm Medical Eracial or must be profiled at once.	by Funeral	11. Marital Status 12. Was Decedent Armed Forces? 13. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 16. Yes 2 14. Was Decedent Armed Forces? 16. Yes 2 14. Was Decedent Armed Forces?			es? 2 _X No	If Yes, specify Cuban, Mexican, Puerto				in? (Spe Puerto	Specify Yes or No- to Rican, etc.) 14. Race - American Black, White, etc. Specify: White				etc.
netur dicsit	eted	(Sp	15. Deceder	nt's Education st grade completed)		(Give	dent's Usual	done di	urina most (of workii	na .	16b. I	Kind of Bus	iness/Inc	iustry
then then	Be Completed		Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of work life. DO NOT use retired) N/A									
t Hygi other /ent, I		17. Father's Nam	e (First, Middle,	Last)			N/ P		18. Mother	's Na <i>m</i> e	(First, Midd	le, Maide	N/A n Sumame)	
Menta arked atic ev	ToB	Nando Santoni Jr.									beth Baltierra				
ealth and m 27 Is m her traum		Elizabet	h Balti	erra M	other	1344	ng Address (Sugar	WOO	d Circ	cle,	Essex	ber, City	or Town, S	tate, Zip 221	Code)
tment of H tant: If ite		` 4 □Donation	2 Cremation 5 Other (S		tate C	Place of Dispo emetery, crer rdens	natory or oth of Fai	e <i>r pl</i> ace th	J	ne 3	ate 0 ,2 005	Ros	ocation - C edale,	MD.	wn, State
Departr Importa eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate									21222				
Medical and phasician and the private francis	iner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										_			
/sician and e burial-transit	cai Examiner	that initiated ever	าเร	С											
	edicai	that initiated ever	ent pregnant 12 months?	c	ome of pregnanth 2 ☐ Fetal	uence of): incy I death 3	Ectopic preg Other (spec						23d. Date Monti		•
n signed by the attending physician and uid be detached for use as the burial-transit	by Physician/Medicai	IF FEMALE: 23b. Was deceded in the past 1 Yes 2	ent pregnant 12 months?	c	ome of pregnant 2 ⊟ Fetal not at time of de	ncy 3 = eath 5 =	Other (spec	eify)	n in Part I.				Monti	ute to the	Day Year
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24 hours after death. Funerel Director: After this certificate has been signed by the attending stelled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1	erred to medica No ath 5 Pendir investir	C	partient 2 Injury Day Year) 5 Injury - At ho letter (Specify Lence) est of my know is of examinat	ncy death 3 = ath 5 = the unit of the unit	t 3X DOA A M Docurred at	Other Other Other Orfice	26. Place o 4 □ Nurs at at as 2 ▼No	cing Hom	24a. Wa aut per 1/2 Yes (Check only be 5 Res 8d. Describe City or Tour Cle,)	s an oppy formed? 2 No one) sidence how inju (Street ar wm, State	Month use contrib No 3 24b. We pride the pride	h uute to the Proba	Day Year P cause of death bly 4 Unkn sy findings avail pletion of cause UN Ink Route Number, Te Count
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			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	rtment of F			giene leg. 19 . ()	0.5	21225
			Decedent's Name (First, Middle, L.	ast)		-		2. Date of Dea		0 0 -	3. Time of Death
	Physicia /Medic		Robert Dani	el Spauld	ing			June 22	, 2005	Year	4:18 P M
	Examin		4a. Facility Name (If not institution, gi				Location of Death)		ity of Death	
			516 Chalcot Squa			Essex	If I ladar 04 Hrs	122		imore	
	Funeral			Sex 7. Age XX□M 2□F	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	Cou	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		51 Yrs.		<u></u>	Jan28,	1954	wes	tVirginia
	ylanc how	_	10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Ba-fs	ctor	MD Balti	more	Ess	sex					1 Tes 2 No
	or 28	Dire	10e. Street and Number	Carra		10f. Zip Code	1	1	10g. Citizen o	f What Cou	untry?
	s 23a	by Funeral Director	516 Chalcot			2122			USA		dan fadina
	ter de Items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?	1	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Puert	Decity Yes of No- Dican, etc.)	14. H	ace - Amen lack, White,	rican Indian, e, etc.
36	urs aff	by F	3 Widowed 4 Delivorced	1√DYes 2 □ No If Yes, Give Year or Dates:		I□Yes X□No	Specify:		Spec	#Whi	te
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner quat be multified at	Completed	15. Decedent's I	Education	16a. Deced	lent's Usual Occup	ation	king	16b. Kind of	Business/lr	ndustry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5-	life. L	OO NOT use retired	daning most of wor	All 19	Home	Imp:	rovement
2	led w lygien her th		12th 17. Father's Name (First, Middle, Las	41	Remo	odeling	40. Mathada Nas	- Visa A Alidella			
Maryland	ntal Hed of	Be	Willis W. Sp.	,				ne (First, Middle,		ime)	
7	should bd Me mark matic	Ļ	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street		na W. H		m, State, Zi	ip Code)
S	nd 2 string at trau		Diana Glover	/sister	516	Chalcot	Square	e Balti	more	MD	
re,	of Heal		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location		fown, State
altimore,	Page nent c int: if iry or		1 ☐ Burial ②☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		Bayview		1/10	5 05	Balt	imor	e MD
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it whedical Experiment counties at once.		21. Signature of Funeral Service Lice	ensee	00 22	. Name and Addre	ss of Facility Co	_			meofEssex
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	polications that caused	the death o not enter	er the mode of dyin				MD Z	Approximate
П	Physician		Immediate Cause (Final	y one cause on each line		est inj					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	consequence of):	Jen Ing	uries		-		
ı.	Examiner		Sequentially list conditions	b							
J	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (or as a	consequence of):						
	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of):					-	
68760,	icate be executed physicien and s the burial-transit	aiE								1	
687		edicai		d							
Вох	death certifii e attending p ad for use as	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Tetonia necessoro			23d. C	Date of deliv	very
m.	9 9	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1∐Live birth 2 4∏Pregnant at t 9∏Unknown		Ectopic pregnancy Other (specify)				Month	Day Year
P.0.	at the	hys	9 🗆 Unknown								
Ś	law requires that the as been signed by th 2 should be detacht	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	J		the cause of death?
ecord	v require been si should t	Completed								3 10	Dabiy 4 Donkhown
3ec	e law has b	mple						24a. Was a autop: perfor	sy		topsy findings available completion of cause of
a R	Th age							1 Yes	2 No	1 Yes	2 No
of Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No	Hospital: 1 Inpatier	nt 2 ER/Outpatien	t 3 DOA Oth		th <i>(Check only or</i> ome 5☐ Resid		that (Case	otil Goope
of	iding Physician: th. After this certifica funeral director, p	n: To	27. Manner of Death	28a. Date of Injun	/ 28b. Time of						
ion	Attending r death.	atio	1 □ Natural 5 □ Pending 2 ☑ Accident investigati	on Found 6-21	rear) Found 4:		Yes 2 X No	subject	thile.	6511 a	in top of
Division	r Atts er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm, str. (Specify)	eet, factory, office			treet and Nun		ral Route Number, alw + Squarl
ā	ital or its eft rai Di			outs	ide of res	idence		ESSEX	0 0	inone	in D
	To the Hospital or Attandi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical		Physician: To the best of aminer: On the basis of	examination and/or inv						
	To the within 24 To the Complete	Med	29b. Signature and title of certifier	and manner stat		29c. Licens	e number	2	29d. Date sign	ned (Month	, Day, Year)
}	F 3 F 8		-	mid		OCME	C		June 2		
	1		30. Name and address of person wh	o completed cause of de	ath (Item 23a) (Type,	Print)					
_			LING LI,	mid		111 Per	n Street	Baltim	ore, M	aryla	ınd 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1					
	Registr	ai	JUN 2 8	2000 Eller	12 - 15 A	Lagrage 1					

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and file of certified

LUK 31. Date filed (Month, Day, Year)

327 Registrar's Signature

JR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 2 8 2005

TERRY

ORIGINAL

MD

29c. License numbe

DO015144

9005 Cheviolet Dr. Ste. 103

29d. Date signed (Month, Dey, Year)

June 27, 2005

21043

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) St Year 10,05 A Month **Physician** NY Corneitha E. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner I form Anne Ar model 15 y or to en If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Hours Days North Carolina 1 ☐ M 2 🛱 F Director 229-22-4645 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√3No Director Anne Arundel Severn Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21144 United States 1423 Virginia Ave. or items 23e Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify-35 Nidowed 4 □ Divorced "netural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emanuel Francis Fale Lilly Bishop Burriss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an William R. Smith, Jr. / Son 1423 Virginia Ave. Severn, MD 21144 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 23, x⊠Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Importent: If eny injury or soce. Dulaney VAlley Mem. Gar. 4 □ Donation 5 □ Other (Specify) __2005___Timonium, Maryland 21. Signature of Funeral Service Licensee Kirkley-Ruddick Funeral Home P.A. 20009 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac ir respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) **Examiner** MA スタトリイ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a winsequence of): by Physician/Medical Examiner Due to (or as a consequence 68760 Physicien: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in 23e. Did tobacco use contribute to the cause of death? me underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25 No 1 ☐ Yes 2 ☐ No 1 Tyes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 2 ER/Outpatient 3 DOA 1 Inpatient 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Hospitel or Attending 1-DNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No death. after death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a

To the Funerel C

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifier Medical To the 29c. License number 29b. Signature and itle of certifier 48006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 150197

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 8 2005

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:00 AM M 23, 2005 June Sami Khalil Suleiman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6520 East Halbert Road Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 ☐ F Months Hours Min Yrs. Director 58 March 27, 1947 Palestine 301-54-0760 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits e 23a or 28e-f show 10a State 10h County show 1 Yes 2 No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6520 East Halbert Road 20817-5414 death 1 <u>United States</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. THEFT Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 21 Married Baltimore, Maryland 21215-0036 ö 1 Tes 2 No Specify: the Medical Exten 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ CPA-Financial Planner Tax & Accounting permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygis important: If item 27 is marked other up once. other 17 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Khalil Ahmed Suleiman 2 Hasna Khatib 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6520 East Halbert Road Bethesda, Maryland 20817-5414 Penelope Mitchell/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park June 24, 2005 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fur al Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 Year disease or condition resulting in death) Acute Leukemia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jacass of Plu) that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1 Yes 2**X** No Division of Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Thomicide hours after within 24 hours af To the Funeral C 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number LO TOO D0033293 June 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, M.D. 5454 Wisconsin Avenue #1300, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) State Registrar

	1 - For State Registrar	State of Maryland	Department of Health Certificate of Deat		giene Reg 2:0 05 2	21329
Physician	Decedent's Name (First, Midd		C+ and	2. Date of De Month	ath Day Year	3. Time of Death
/Medical Examiner	L1	cia Margaret n, give street and number)	Sterk 4b. City, Town, or Location	June 20 on of Death	6, 2005 4c. County of Death	4:31 A M
	1206 Brook M		Towson		Baltimore	
Funeral Director	5. Social Security Number 130-12-4378	6. Sex 7. Age (In yrs. last	Yrs. If Under 1 Year If Under 1 Year Months Days Hour		th y, Year) 7,1918 Ita	lace (State or Foreign try) y
and and	Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	own or Location			0d. Inside City Limits
a-fshe	Maryland Balti	more To	wson			1 ☐ Yes 2XXNo
vith the Ma nor 28a-fs	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cour	ntry?
death v	1206 Brook M	12. Was Decedent Ever in U.S.	21286 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexical Control of the	Origin? (Specify Yes or No	U.S.A. 14. Race - Americ	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. item 27 is marked other than "natural; or items 23s or 28s-1 show other traumatic event, its Medical Eventual traumatic event, its Medical Eventual be notified at To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorce	If Yes Give	If Yes, specify Cuban, Mexi-		Specific	^{etc.} ite
5-00 72 hour	15. Deceder		6a. Decedent's Usual Occupation	rost of working	16b. Kind of Business/Ind	
	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during m life. DO NOT use retired) Homemaker	lost of Working	Own Home	
ind 2 be filed tal Hygin of other event, il	17. Father's Name (First, Middle			other's Name (First, Middle,		
ylar ylar i Menta barked barked barked To F	Virgilius	Cossovel		Victoria	Camalich	
Mar nd 2 st lith and 27 is n	19a. Informant's Name/Relation:		19b. Mailing Address (Street and Nur. 1206 Brook Meado		er, City or Town, State, Zip wson, Maryla	· ·
Ore, es 1 ar of Hea of Hea r othe	20a. Method of Disposition 1 🎇 Burial 2 □ Cremation	20b. Plac	e of Disposition (Name of etery, cramatery or other place)	Date	20c. Location - City or To	
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, Item 2006.	4 Donation 5 Other (3	Mem Mem	orial Gardens 22. Name and Address of Fa	6-30-2005	Timonium	Maryland
Balpermi permi limpo any ii	and WH	ng an	1050 York R	RUCK TOW		Home, Inc. 21204
	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	r complications that caused the death. only one cause on each line.		as cardiac or respiratory as	rrest,	Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)	Due to (or as a consequer	DEMENTIA			YEARS
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68760, tificate be executed as the burial-transit	resulting in death) Last	Due to (or as a consequent	ice of):			
68760 tificate be e g physiciar as the burit		d.				
Box 6 death certification of for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance	ath 3 Ectopic pregnancy		23d. Date of deliver	ory Day Year
. 0 00	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at time of deat 9□Unknown	h 5 ☐ Other (specify)			,
S s s s s	Tarth, Other significant conditi	ons contributing to death but not resulting	ng in the underlying cause given in Pa		obacco use contribute to th Yes 2⊠No 3□Prob	
cord wraquii been s should				24a. Was		psy findings available
				autor perfo		npletion of cause of
of Vital Ro Physician: The I this certificate har all director, page	25. Was case referred to medical examiner?	Haenital:	04	ace of Death (Check only o		
<u>~</u> × ∞ ±		28a. Date of Injury 28	t/Outpatient 3 DOA 4 documents b. Time of Injury at Work?	Nursing Home 5 PResident Resident Page 1	dence 6 Other (Specify now injury occurred	/)
Division or Attending after death. Director: Attention ertification	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	gation	M 1 ☐ Yes 2		Street and Number or Pure	I Pauta Mumbas
Division of Division of Italian or Attending Plants after death. The division of the function	4 ☐ Homicide deter	ined 28e. Place of Injury - At home building, etc. (Specify)	s, ramit, street, ractory, onice	City or Tov	Street and Number or Rura vn, State)	i noble Number,
Hospi 14 hours 15 Hospi 16 Hours 16 Hours 16 Hours	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To the best of my knowle Examiner: On the basis of examination and manner stated.	ndge, death occurred at the time, date n and/or investigation, in my opinion, o	and place, and due to the death occurred at the time,	cause(s) and manner as st date and place, and due to	ated. the cause(s)
To the within 2 within 2 comple	29b. Signature and title of certific		29c. License numbe	er 7 0 2	29d. Date signed (Month,	
	Asce	Mms	V 583	,05	June 27	+005
12	30. Name and address of person	who completed cause of death (Item 2:	Ba) (Type, Print) Wardes St 70	WSON MD	21204	
State Registrar	31. Date filed (Month, Day, Year JUN 2	8 2005 32. Registrar's Signatur	Specie			

		For	State of Ma	aryland .				Mental Hy			31330
	×	Registrar 1. Decedent's Name (First, Middle, I	Last)		Cenilica	te of Dea		2. Date of D		005	3. Time of Death
Physic	_	Jeffery A. Shields						June	2 Pay	7 2005	9:100 M
/Medi Exami		4a. Facility Name (If not instriction, g	nive street and number)	00.1	4b Sity	, Town, or Local	tion of Death			County of Death	1
	€	Maryanada	neral Hu	SPITC (III) yrs. last	II D	11+1MOI	nder 24 Hrs.	T/	idh	O Right	nplace (State or Foreign
Funeral Director		5. Sòcial Security Number 6. 220-64-7629	. Sex 7. Age 1 X M 2 ☐ F	50 50	Yrs. Months			8/Date of B (Month, D		Mary	untry)
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the N	rect	10e. Street and Number				ip Code			10g. Citi	zen of What Co	untry?
th with	al Di	2112 Ashton Street				21223				USA	
er dea	nner	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. Was Dec If Yes, sp	edent of Hispani ecify Cuban, Me	c Origin? (Sp xican, Puerto	pecify Yes or N o Rican, etc.)	lo-	 Race - Amer Black, White 	
rs afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【 Divorced	d 1 □ Yes 2 XIN If Yes, Give Year or Dates:	10	1 🗆 Yes	2 X No Spe	ecify:			Specify: Blac	lr
2 hou		15. Decedent's (Specify only highest of		1	6a. Decedent's Us	ual Occupation ork done during	most of wor	kina	16b. Ki	nd of Business/I	
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retired)		·······································		~ = .	.
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ally failure A in a cooologo should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other then "neturel", or Items 23s or 28s-1 ehow unetic event, the Madical Examinar must be notified at	To Be	Paul A. Shields	,				Lil	lie Dous	et		
	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing Addres	·				r Town, State, Z	ip Code)
and and and m 27 in m 27 in her tre		Zelda M. Smith/ Sist	er	20h Bina	5 Travis		Baltin	Date MD		one City of	Favor State
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre once.		20a. Method of Disposition 1X Burial 2 □ Cremation 3		cem	e of Disposition (Na etery, crematory or	other place)	06.20			cation - City or	own, State
Definition Pages Department of mportent: If it ony injury or o	l ä	* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lig		Mt. Zi	on Cemetery	7 and Address of F	06-30- acility	-05	Lanso	lowne, MD	
permit. Departn Importe eny injt		الماسالة	Jours		Wylie H	Tuneral Ho	me 638	N. Gilmo	r St.	Baltimore	, MD 21217
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each lin	the death. I	Do not enter the mo	ode of dying, suc	h as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
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/Medical Examiner		resulting in dealthy	Due to (br as	a consequen	donne	-diti	(
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cate be executed physician and the burial-transit	ai Ex	resulting in death) Last	Due to (or as	a consequer	nce (f):				,	′	
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wrequires that the death certific been signed by the attending pshould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐Live birth			pregnancy				23d. Date of deli	
deat be attr	sicie	in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	4∏Pregnant at 9☐ Unknown							Month	Day Year
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law requires as been sign	Completed							24a. Wa		24b. Were au	topsy findings available
The lar	om							per 1 Tyes	opsy formed? 2 No	death?	ompletion of cause of 2□ No
	Be	25. Was case referred to medical examiner?	Line-hali				Place of Dea	th (Check only	one)		
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orn rding th. : After fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury M	Work? 1 ☐ Yes	2 🗌 No		•	_	
INISION I or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home c. (Specify)	e, farm, street, facto	ory, office		28f. Location City or To	(Street an	d Number or Ru	ral Route Number,
itel or rel Dir led in											
Hosp 24 hou Fune stely fil	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best kaminer: On the basis of and manner sta	f examination	edge, death occurre n and/or investigation	ed at the time, da on, in my opinion	ite and place , death occu	red at the time	e cause(s) e, date and	and manner as I place, and due	stated. to the cause(s)
To the Hospitel or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Med	29b. Signature and title of certifier	A .	> /	2	9c. License num	nber O O	-00	29d. Dat	e signed (Month	, Day, Year)
		1 SALKOR	,016	2091	Nh 1		X42	33	Jur	re 25.	2005
17	and on the state of the state o	30. Name and address of perion wi	ho completed cause of d	leath (Item 2:	3a) (Type, Print)	arila	nd (popular	2//	locail	-01
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S Regis	tate trar	31. Date filed (Month, Day, Year)	105 Maria	15.	Goste						

			roi	artment of Health and Mental F ertificate of Death	lygiene Reg. No. 2005 21331
	Physici		1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Bon Secours	4b. City, Town, or Location of Death Baltimore	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1. M 2 F 7. Age (In yrs. last birthday, 1. M 2 F 54 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. 11-09-	Birth Day, Year) 9. Birthplace (State or Foreign Country) 1951 Maryland
	Maryland of ehow lied at	tor	10a. State 10b. County 10c. City, Town or L	imore	10d. Inside City Limits 1 X Yes 2 ☐ No
	with the e or 282 Lbe noti	Director	10e. Street and Number 901 Cherry Hill Road	10f. Zip Code	10g. Citizen of What Country?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23e or 28a-f ehow or other traumatic event, the Medical Examiner must be notified at	by Funeral		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	d within 72 ho piene. r then "netur the Medical.	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) Laborer	16b. Kind of Business/Industry Dry Dock
yland;	2 should be filed and Mental Hygi is marked other aumatic event, II.	To Be C	17. Father's Name (First, Middle, Last) Earl Smith	18. Mother's Name (First, Midd Delores E. Smith	
	alth and 2 sho			ing Address (Street and Number or Aural Aoute Nur 11 Cherry Hill Road Baltimore,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra 900.99.		20a. Method of Disposition 1	matory or other place)	20c. Location - City or Town, State Lansdowne, MD
Balt	permit Depart Import eny inj			2. Name and Address of Facility Nylie Funeral Home 638 N. Gilm	or St. Baltimore, MD 21217
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	unodeficiency Syndru	Onset and Death
,8200	death certificate be executed the attending physician and ad for use as the burial-transit	dical Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
P.O. Box 6	y th	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	law requires that as been signed b 2 should be deta	d by	Part II. Other significant conditions contributing to death but not resulting in the t		d tobacco use contribute to the cause of death? ☐ Yes 2 100 3 ☐ Probably 4 ☐ Unknown
al Records,	The ate h	Complete			topsy prior to completion of cause of death?
of Vital	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Mainpatient 2 ☐ ER/Outpatie	26. Place of Death (Check on an an an an an an an an an an an an an	y one) asidence 6 □Other (Specify)
Division c	ing After une	Certification:	27. Manner of Death 1 S Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28a. Date of Injury (Month, Day Year) Injury 28b. Time (Month, Day Year)	Work? M 1 ☐ Yes 2 ☐ No	e how injury occurred
Divi	Hospitel or Attend :4 hours after death Funeral Director: , tely filled in by the f		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location	n (Street and Number or Rural Route Number, Fown, State)
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	fedical	29a. Centifier (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
	To with	Σ	29th Signature and title of certifier Medical House of	29c. License number OYSTYY	29d. Date signed (Month, Day, Year) UW 251 2005
1.	3 Y		RO. Viame and address of person who completed cause of death (Item 23a) Type Citar W OSUM, BM Secaus Aspital	Print) 2000 West Baltimoru Strut	Baltimors, Haryland, 21223
	Sta Registi		JUN 2 8 2005 32. Agistrar's Signature	porte	

Brian Sampson 05-04251 RJ

2005 21332 Year 3. Time of Death 2:26 a. M
Year 2:26 a.
2:26 a. M
County of Death
Birthplace (State or Foreign
Country) Maryland
10d. Inside City Limits
1 X Yes 2 No
zen of What Country?
USA
14. Race - American Indian, Black, White, etc. Specify: p1 - 1-
Black nd of Business/Industry
Schools Sumame)
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r Town, State, Zip Code)
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Onset and Death
23d. Date of delivery Month Day Year
se contribute to the cause of death? No 3 Probably 4 Dunknown
24b. Were autopsy findings available prior to completion of cause of death? 12 Yes 2□ No
Other (Specify) y occurred
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Number or Rural Route Number, 1100 by ch West
and manner as stated. place, and due to the cause(s)
e signed (Month, Day, Year) e 23, 2005
Maryland 21201

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	Physici	an	Decedent's Name (First, Middle, Last)			1	-	2. Date of Dea Month	Day Y	3. Time of Death		
	/Medic	al	RoseAnne 4a. Facility Name (If not institution, give s	troot and number		So I omo	N Location of Death	JUNE	25 200 4c. County of			
	Examin	ier	9031 ALLENSWOOD F			RANDALL			BALTIMORE			
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h o	Birthplace (State or Foreign Country)		
	Director		200 10 0100	M 2₹F 80	Yrs.			12/17/	1924	PA		
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits		
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21215-0036	d within 72 hours after death with the Maryland jene. Ir than "natural", or itams 23a or 28a-f show I're Modical Examiner must be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	5. 13. V	Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecry Yes or No- Rican, etc.)	Black,	White, etc. WHITE		
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ion of	ding Ph h. After th funeral	-	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor	y at		now injury occurred	<i>Эрвену)</i>		
Division	al or Atland s after death il Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tox		or Rural Route Number,		
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)	To that within 2.	W	29b. Signature and title of certifier	M.D.		29c. Licens	00549 L		29d. Date signed (1 06 - 25	Month, Day, Year) - 2005		
	10		Kod Rildo B.	moleted cal sept death (Item	01 W.	BELVERE	are Ave.	BALT	imore 1	-2005 4D21215		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health d Mental Hygiene For State Registrar Reg. NZ 0 0 5 Certificate of Deat 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Tyler June 2005 1155 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park, Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5 Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F 579-34-1919 73 Director Oct 27,1932 Washington DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State , or Items 23a or 28a-f show 1∏Yes 2∏No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2515 "R" Street SE #4 20020 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 24 Married 1 □ Yes 2 No **Black** Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tenth Mechanic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Tyler Adele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Johnson Tyler/Wife 2515 "R" Street SE, #4, Washington DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or June 17, Mt Olivet Cemetery Washington DC * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert G. Mason Funeral Home anyi 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a co acral Deculibus ulcens **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Accident Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? and consular 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 1 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 10 Hospital: Other: Certification: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1 Watural 2 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO SICM D 50175 completed cause of death (Item 23a) (Type, Print) RShire 12 c (d(ana 31. Date filed (Month, Day, Year) gistrar's Signature State JUN 2 8 2005 Registrar

		í	For State Registrar	State of Ma	aryland		irtment of H tificate of I			lental Hy	/giene Reg. Ng)5	21335
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	Director		Usual Residence of Decedent	X	79					80	09	25		VA
	darylar f show	ō	10a. State 10b. County MD NA			Town or Lo altin								10d. Inside City Limits 10d. Yes 2 No
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38	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Exatt and tunal by mullified at	by Funeral Director	11. Marital Status 1 □ Never Married ※※ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		ĺ	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 XNo	ispanic (an, Mexic Speci		ecify Yes or N Rican, etc.)	0-		ck, White,	can Indian, etc. lack
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altimore,	Pages 1 and nent of Healt int: If Item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	ce ol Dispo: netery, crem	sition (Name of natory or other plac	:е)	C)ate	20c. L	ocation -	City or T	own, State
Ē	permit. Pages Department of Important: # It any injury or o	ı	* 4 Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen)	Kin		morial			24/05	Ra	nda	llst	own, Md
Ba	perm Depa Impo any i		Pala /	March		Ma 4	Name and Add arch F/1 300 Waba	T Wê ash	Št Ave,	Balt	imor	ce,	мd	21215
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	To the Hospital or within 24 hours after To the Funerat Dir completely filled in I	edical (29a. Certifier Certifying Ph. (Check only one)	vsician: To the best of iner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tir restigation, in my o	ne, date pinion, d	and place, a leath occurr	and due to the ed at the time	cause(s , date an) and ma d place,	anner as s and due t	stated. o the cause(s)
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			Decedent's Name (First, Middle,	, Last)							2. Date of Dea	ıth		3. Time of D	
٠	Physici /Medio		Mary	E	lizal	beth			Tib	bs	Month JUNE	Day 22, 2	Year 225 E	:40 A	М
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L	Director		220-20-0485 Usual Residence of Decedent	1□ M ¾ □ F	81	Yrs.					05 24			MD	
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	th the	Director	10e. Street and Number				10f. Zip	Code		-		10g. Citizen o	of What Cour	ntry?	
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	ar dez	Funeral	11. Marital Status	12. Was Decedent	?	S. 13.	Was Deced If Yes, spec	lent of His cify Cuban	spanic Ori n, Mexicar	igin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)	14. R	lace - Americ lack, White,		
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i)	Bu	~	_)	D	3725	54			61	22/	20	
2	1		30. Name and address of person v	vho completed cause of	death (Item	23a) (Type,			<u> </u>						
2		7.7	OON P.LIM M.I	7601 09	SLER_	DRIVE	TOW	ISON	MAR	YLAN	D 212	714			
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	negisti	u r .		- Walder	1 15	100	3								

				artment of Health and Mental Hy	giene
	Physici	an	1. Decedent's Name (First, Middle, Last) Naomi A. Tores	2. Date of De JMONTE	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Exami	eı	1114 Oakwood Road	Glen Burnie	Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		th 9. Birthplace (State or Foreign
	Director		219-12-8587	Dec. 11	, 1917 MAryland
	uryland show		10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits
	he Ma 18a-f	ecto	Maryland Anne Arundel Glen But		1 ☐ Yes ¾☐ No
	3a or 3	Funeral Director	1114 Oakwood Road	10f. Zip Code 21061	10g. Citizen of What Country?
	death	nera		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	United States 14. Race - American Indian,
36	s after , or Ita	by Fu	1 Never Married 2 Married 1 Tyes 2 No	1 ☐ Yes 2 ☑ No Specify:	Black, White, etc. Specify: White
21215-0036	thour	ed b	3 Wildowed 4 Divorced Year or Dates:	ident's Usual Occupation	16b. Kind of Business/Industry
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Σ,	and 2 ealth a n 27 to			4 Oakwood Road Glen Burn	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic avent, It a Medical Examiner must be notified at once.		T Double 2 Dorellation 3 Direlloval notificate	osition (Name of matory or other place) June 28,	20c. Location - City or Town, State
<u>=</u>	artmen artmen ortant: injury		'4 □Donation 5 □Other (Specify) Glen HAver 21. Signature 1 □uneral Service Licensee 22	n Mem. Pk. 2005 2. Name and Address of Facility	Glen Burnie, MD
Ba	permi Depar Impo any ir		1000	Kirklev-Ruddick Funeral H	Iome P.A.
	₩.		23a. Part I. Enter the disease, or complication that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	#21 Crain Hwy. S.E. Glenter the mode of dying, such as cardiac or respiratory a	rrest, MD 21061 Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition	ute Jun Carcol	-Jonset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
9		Jer	Sequentially list conditions, if any, leading to immediate b		
V	ransit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c,		
8760,-	cate be executed bhysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):		
687	ficate physics the t	edical	d		
Вох	death certifica attending ph for use as t	M/W	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	⊒Ectopic pregnancy	23d. Date of delivery
о. В	e deat the att	Physician/M		Other (specify)	Month Day Year
م:	res that the de signed by the a be detached f	, Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underfying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
Vital Records,	The law requires that the death certific tle has been signed by the attending p age 2 should be detached for use as	d by			Yes 2 □ No 3 □ Probably 4 X Unknown
000	as been size should b	Completed		24a. Was	
Ž		Com			death? Y No 1 Yes 2 No
Vita	ician: certific	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only of the Check only only only only only only only only	nne)
	£ 25 8	. To	27. Manner of Death 28a. Date of Injury 28b. Time of	IL 3 DOX 4 INdising Home 3. Resid	dence 6 Other (Specify)
ion	Attanding F death, ctor: After y the funera	ation	1 Transport 1	Work? M 1 Yes 2 No	
Division of	I or Attano after deatl Diractor: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)
	lospital of hours at uneral Districted in the filled is		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death		
	T 4 F 0	edical	29a. Certifier (Check only one) Check only one) 2	vestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
	To the within 2 To the complet	M	29b Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	,		() m(KN)	151151	June 27 2007
	lo		39-Name and address of person who completed cause of death (Item 23a) (Type,	Print of AlDrif 6/p.s	Som Md 2 1061
W	Sta	te '	Date filed (Month, Day, Year) 32. Registrar's Signature		
	Registr	ar	JUN 2 8 2005 Beneve &	baseles	

			State of Maryland / Depart	ment of Health and N	, ,		21220
			1. Decedent's Name (First, Middle, Last)	icale of Dealif	2. Date of Death		3. Time of Death
	Physici /Medi		Donald Otto Tucker			24, 2005 Year	2:35 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number) Rockville Nursing Home	b. City, Town, or Location of Death Rockville		4c. County of Death Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign intry)
	Director		579-05-0636 180 M 2 F 93 Yrs. W		Aug. 10,	1911 Nort	h Carolina
	arylanc show	_	10a. State 10b. County 10c. City, Town or Locati				10d. Inside City Limits
	28a-f	recto		kville 10f. Zip Code	100	g. Citizen of What Cou	1 ☑ Yes 2 □ No
	th with 23a or	ai Di	1517 Auburn Avenue	20850		nited Stat	•
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Madical Examiner must be natified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was If Ye	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
036	72 hours aft "natural", or	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced Year or Dates: WW II	Yes 2⊠ No Specify:		Specify: Wh	ite
21215-0036	a within 72 ho piene. r than "natur the Modicel	Completed	(Specify only highest grade completed) (Give kind	's Usual Occupation d of work done during most of work NOT use retired)	ting 16	3b. Kind of Business/Ir	ndustry
212	7 5 -	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	Employed		Plastics	
b		Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
Maryland	should be nd Mental marked o	2	Malcolm Mack Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Dollie ddress (Street and Number or Run	Belle V		0.11
Ma,	and 2 salth an alth an 27 is			ıburn Avenue, Ro			
ore,	ges 1 a t of He If itam or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cometery, cremato Montgomery	on (Name of	Date 20	c. Location - City or T	own, State
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic a <u>once</u> .	1	Crematorium	m, Inc. 200)5	ethesda, M	-
Ba	Depa Impo any is		M00198 Robe 300 W	ame and Address of Facility Ert A. Pumphrey Vest Montgomery A	Funeral H	lome/Rockvi ville, MD 2	ille, Inc.
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Coronary area. Due to (or as a consequence of):	y disease			Onset and Death
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	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1:			
o,	execu an and rial-tra	Exar	that initiated events resulting in death) Last c. Due to (or as a consequence of):	alsease			
8760,	cate be executed physician and the burial-transit	dicai	a stypertension				
	death certifi e attending I id for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	arv
	0 0 0	Physician/Me	in the past 12 months?	opic pregnancy ner (specify)		Month	Day Year
<u>α</u>	that the ed by detac	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
rds,	w requires been sign should be	ed by			1 ☐ Yes		pably 4 □Unknown
Record	law as b 2 s	Completed			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
	ate pag	e Con	OF Was seen selected by a start of		performed	d? death? [No 1 ☐ Yes	3)X NO
f Vital	lysicia lis cer direct	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Out.	n_(Check only one) me 5□Residence	e 6 Other (Specific	v)
n of	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe how i		7
Division	I or Attand after death Diractor: /	ficat	3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	t and Number or Rura	I Route Number
	tal or a rs after al Dira ed in b	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	THOUSE NUMBER,
	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occ and manner stated. 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	urred at the time, date and place, a gation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To tha within 2 To tha complet	Me	29b Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
- 60	41	2	ratured lowsko May, Mo	D5/9/6	U	Tune 25,	2005
P	1		30 Name and address of person who completed cause of death (Item 23a) (Type, Print	1/10 Dita B-11	on Ron	trillo 1	ND 20850
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	110/11/0/	V/ NOU	101116,11	IN accord
DH	Registra		28 2005 George H.	Court >			
∨ורוכ	IH 17 Rev 1/20	.01	ORIGINAL				

Physicia /Medic Examin

Tarbet, Caroline

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1 - State Registrar Certificate of Death Reg. No. 200									
ì	°. Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year Total 2.005			
	/Medic	al	Caroline Anderson Tarbet		Ab City Town or	Location of Death	June 24	, 2005 4c. County of Dea	8:59 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number)					Baltimo		
E	uneral		Greater Baltimore Medical Centers S. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthday)	If Under 1 Year	SON If Under 24 Hrs.	8. Date of Birth	Birth 9. Birthplace (State or Foreign		
	rector		239-44-2572 ^{1□M 2} √ 72	Yrs.	Months Days	Hours Min.	Oct 12,	1932 Nor	th Carolina	
nd	* 0:2/		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Loc	cation				10d. Inside City Limits	
Aaryla	Sho	ō		nervill					1 □ Yes 2 No	
the 1	28a-	rect	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?	
h with	23a oi	ai D	11638 Greenspring Avenue		21093			JSA		
.UU.So hours after death with the Maryland	ems er a	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.: Armed Forces?	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
s afte	i or i	by FL	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No ☐ If Yes, Give		☐ Yes 2 No	Specify:		Specify:	white	
3-0030 72 hours af	od other than "natural", or liams 23a or 28a-f show event, the Madical Examinat must be incliffed at	ed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Business		
within 72 ene.	Medis	Completed	(Specify only highest grade completed)	(Give I life. E	kind of work done of OO NOT use retired,	during most of work	ring			
A Mitt	er tha	E C	Elementary/Secondary (0-12) College (1-4or 5+)	Cashi	er			Restaurant		
yiand A	d oth	Be	17. Father's Name (First, Middle, Last)			Janie Ro	e (First, Middle, M			
yian nould be	is marked eumatic ev	၉	Edgar Horace Anderson 19a. Informant's Name/Relationship (Type, Print)	10h Mailie	n Address (Camata			City or Town, State, .	Ti- Codel	
Mang d 2 st	importent: If item 27 is marked any injury or other treumatic ev once.		Mary T. Cregger / daughter	31 Her	nry Avenu	ie; Balti	more, MD	21236	zip Code)	
s 1 an	item other			lace of Dispos	sition (Name of natory or other place		Date 2	20c. Location - City or	Town, State	
Page Page	int; If	li			ey Mem Gard		/05	Timonium,		
Saltimore, permit. Pages 1 a	porte y inju		21. Signature of Fun and Service Libensee		. Name and Addres		llomo	1050 York		
n ac	E # 9		1 Jelly Olley		ck Towson			Towson, M		
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
	sician edical		Immediate Cause (Final disease or condition resulting in death)	2/5	12					
	miner		Due to (or as a consequ	iende or):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):						
cuted	nd transit	Examin	Cause (Disease or injury that initiated events c.							
oc,	cian a		resulting in death) Last Due to (or as a consequ	ience of):						
death certificate be executed	attending physician and for use as the burial-transit	Medical	d							
OX C	nding use as	-	IF FEMALE: 23c. If yes, outcome of pregnat		1-			23d. Date of de	livery	
death u	d for	Iciai	in the past 12 months? 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year	
D et la	n signed by the a Id be detached f	Physician	9 ☐ Unknown							
	igned be de	by	Part II. Dther significant conditions contributing to death but not resi	Alting in the un	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to s 2 ☑ No 3 ☐ Pi	o the cause of death?	
ord requir	been si should	Completed	Dack of the	2011	100					
e law	has b	mpje	- (CCS)(1000)	90,00			24a. Was ar autops: perform	y prior to	utopsy findings available completion of cause of	
	s certificate has t lirector, page 2 s	e Co	25, Was case referred to medical			OC Place of Door		1□ Yes	2 □ No	
DIVISION Of VITAL RECORDS, Lor Attending Physicien: The law requires t after death	s cert	0 B	examiner?	ER/Outpatient	t 3 DOA Othe	ar		nce 6 □Other (Spe	ocify)	
ב פ ק	After this of funeral dir	n: T	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe ho			
ISIOF Mtendin	or: Af	atic	2 Accident investigation		M 1 🗆 '	Yes 2 □ No				
or Att	Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specif)	me, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,	
pital	erei [29a. Certifier 1 Certifying Physician: To the best of my kno	wledge death	occurred at the firm	ne, date and place.	and due to the ca	use(s) and manner a	s stated	
DIVISION Of VITA To the Hospital or Attending Physicien:	To the Funerel Directory Completely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.							
To th	To th	Me	29b. Signature and title of certifier		29c. License	e number	25	od. Date signed (Mont	th, Day, Year)	
			ree for succes		1) 12	132		6/28/6	/3	
	ι Λ.		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	len or.	Balla	Ad. 71	204	
	3		30. Name and address of person who completed cause of death (Item DEO RGE A BE) ON D B 31. Date filed (Month, Pay, Year) 32. Jegistrar's Signa	ture .	1 -0 -1011	ies VI	104110	o'a -		
•	Sta Regist		31. Date filed (Month, Pay, Year) JUN 2 8 2005 32. Jegistrar's Signa	& A	rode					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	arylan	-	rtment o			ental Hyg	giene Reg. 20 (05	21340
	Physicia	~	1. Decedent's Name (First, Middle				-			2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic	al .	Benjamin Frank							June	23,2	1000	
	Examin	er	4a. Facility Name (If not institution		1.1:		1		ocation of Death		4c. County		
			5. Social Security Number	are HOSP		last birthday)	If Under 1	Sec Year 1	f Under 24 Hrs.	8. Date of Birth	1 <u>Oa</u>	9. Birt	hplace (State or Foreign
	Funeral Director		215-14-8937	1 ⊠ M 2□F	67	Yrs.	Months [Days	Hours Min.	8. Date of Birth (Month, Day 7/5/19	37 (3 (4)	Mar	hplace (State or Foreign untry) 'y Land
	pc ,		Usual Residence of Decedent 10a. State 10b. County		100 0	y, Town or Lo							10d. Inside City Limits
	shov	'n	,	imore	100. 01	Essex	cation						1 Tes 2 No
	28a-f	ecto	10e. Street and Number				10f. Zip Co	ode			10g. Citizen of	What Co	
	ath with the Marylar 23s or 28s-f show	ā	1000 Franklin	Avenue Apt.	807			21221	L		•	S.a.	•
	death	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13. V	Vas Deceder	nt of Hisp	anic Origin? (Spe Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Ame	rican Indian,
< 9	or ite	y Fu	1 Never Married 2 Marr	ried 1⊠Yes 2⊡I		1	☐ Yes 25		Specify:	110011, 010.7	Specia		ite
· 2 00	72 hours after dea "natural", or items	ed by	3 ☐ Widowed 4 ₹ Divorced	Year or Dates:		16a Decer	ent's Usual (Occupation	20		16b. Kind of B		
§	n "na	plete	(Specify only higher	st grade completed) College (1-4or 5	F.\	(Give	kind of work	done dur retired)	ing most of worki	ng	TOD. TAILG OF E	03111033/	nidustry
21215-0036	d with giene ar tha	Completed	Elementary/Secondary (0-12)	College (1-40)) +)	Machi	ne Ope	erato	or		Crown	Cork	& Seal
Benjamin and 21215-0036	be ilied within 72 hours after death with the Maryland ital Hygiene. I hours at tems 23a or 28a-f show nd other than "natural", or Items 23a or 28a-f show avent, the Medical Examiner must be notified at	To Be (17. Father's Name (First, Middle,					18	8. Mother's Name		Maiden Sumai	me)	
<u>\$</u>	d Men narke	٦ م	Franklin Taylor 19a. Informant's Name/Relations			10h Mailie	- Add:0 /C	Stand	Anna R		s City as Tour	Ctoto 3	Tin Codo)
$a_{\rm V}$ or, $B_{\rm e}$ more, Maryland	d 2 sh th and t7 is n traun		Anthony Richard						ve Elkto				.ip C00θ)
	t Heal them?		20a. Method of Disposition		20b. F	Place of Dispo cemetery, cren	sition (Name	of er place)		ate	20c. Location	- City or	Town, State
S S	Page nent o nt: if		1X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S			oudon P		si piaco)	6/27	/05	Baltim	ore,	Maryland
Tay!	permit. Pages 1 and 2 should be filed within 72 hours after des Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items any injury or other traumatic avent, It. Medical Exam her once.		21. Signature of Funeral Service	Licensee									1 home Inc.
	20 = 20		1 de locar	>					r Road B			land	
			3a. Part1. Enter the disease, or shock or heart failure. List	r complications that caused only one cause on each li	d the deat ne.					or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)		NW	lar t	167lla	to	^				
	Examiner			Due to (or as	cess	luence or):	n feur	chò	n				approx 48 his.
		ner	Esquentially list surrollions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to las		шепсе of):							
A	executed n and al-transit	Examiner	that initiated events	o. Sem	-	COPD.							
,09	ate be executed ysician and he burial-transit		resulting in death) Last	Due to (or as	a consec	(uence of):							
Box 68760	physi s the b	dical		d									
»	he death certifical rithe attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			lan				23d. Da	ate of deli	ivery
	death	lcla	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant a 9□ Unknown			Ectopic preg Other (spec				M	onth	Day Year
P.O.	at the	Phys	9 Unknown						in Donal	220 Dideo	hassa usa saa	tributo to	the cause of death?
	ires th signed	by	Part II. Other significant conditi					se given	in Paπ I.	239. Did to			obably 4 Unknown
) or c	w requires that the de been signed by the should be detached	etec	01	onay aten	0.00	a Auro				24a. Was		More	tana diadaga ayadabla
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ta	Physician: The lavithis certificate has al director, page 2	a)	25. Was case referred to medica	ıl .				2	26. Place of Death		2 No No ne)	1 🗆 1 1 1 1 1	2[] NO
<u></u>	nysici	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2	ER/Outpatien		Other:	4 Nursing Ho	me 5 Resid	lence 6 🗆 Ot	her (Spe	cify)
0	ing PI		27. Manner of Death 1 ■ Natural 5 □ Pendii		ıry ıy Year)	28b. Time of Injury		. Injury a Work?		28d. Describe h	ow injury occu	rred	
<u>s</u>	ttendi death tor: A	icat	3 Suicide 6 Could		iury - At h	ome farm str	M eat factory o		s 2 No	28f Location /S	Street and Num	ber or Ru	ıral Route Number,
Div	after a Direct	Certification;	4 Homicide determ	building, e	ic. (Speci	fy)	soi, izoloty, i	JIIIO		City or Tow	m, State)	007 07 110	
	To the Hospital or Attending Physician: The lawinin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	(Check only 2 Medical	ng Physician: To the best Examiner: On the basis of	of examina	owledge, death	occurred at restigation, in	the time,	, date and place, nion, death occurr	and due to the deed at the time,	cause(s) and m date and place,	nanner as , and due	stated. to the cause(s)
	o the ithin 2 o the emplet	Med	one) 29b. Signature and title of certific	and manner st	ated.		29c. l	_icense n	number		29d. Date signe	ed (Monti	h, Day, Year)
	⊬ s ⊢ ŏ		> M.M.	h.			DET	2775	412-3023		6 23 0	5.	
	241		30. Name and address of person	who completed cause of	death (Ite	m 23a) (Type,	Print)	^	~				iD-21237
	2''	= -	Dr. Minus Vo	isitiodes, 9	000	Frai	MIN	Dan	lare Dr	ive, 13	altima	e N	ID-21237
*	Sta Registi		31. Date filed (Month, Day, Year JUN 2	8 2005 32. egist	rars Sign	H A	willed	4					
		1 4			0	- 100							

		rieas	State of M	aryland / Dep			•	_	
		1 - For State Registrar		-	rtificate of		Reg.	2005	21341
Physic /Med		1. Decedent's Name (First, Middle,	Last)	WEST			2. Date of Death	Pag Car	3. Time of Death 1945 PM
Exam	iner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	ath
		Bon Secours 5. Social Security Number		e (In yrs. last birthday	Baltim If Under 1 Year	ore If Under 24 Hrs.	8. Date of Birth	o Ri	rthologo /State or Enroise
Funera Directo		214-26-4524 Usual Residence of Decedent	1□ M X XF	75 Yrs.	Months Days		(Month, Day, Ye	9ar) 30	rthplace (State or Foreign country) MD
yland how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
e Mar sa-f sl	ctor	MD N.	A	Baltin	nore				1X Yes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What C	ountry?
s 23s	- Pa	1010 West Bal				.223		U.S.A	
ter de	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Armed Forces?		If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
ours af	by	3	d 1 □ Yes 2 🔀 1 If Yes, Give Year or Dates:		1 ☐ Yes 🎾 No	Specify:		Specify: B	lack
be filed within 72 hours after death with the Maryland tall Hygiene. All Hygiene "natural", or Itams 23a or 28a-1 show evant, the Medical Evanillar mist be redilited at	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	edent's Usual Occup kind of work done	during most of worki	na 16t	b. Kind of Business	s/Industry
within ne.	I du	Elementary/Secondary (0-12)	College (1-4or 5	5+) life.	DO NOT use retire	ed)			
yidiliu Zizi nould be filed within 1 Mental Hygiene narkad other than " natic event, the Me.	ပိ	6th grade 17. Father's Name (First, Middle, La	na ast)	Ma	il Room		(First, Middle, Mai	Hospi	tal
	To Be	Arthur Peter					Peterso	,	
and Menta and Menta is marked aumatic ev	-	19a. Informant's Name/Relationshi		19b. Mail	ing Address (Street	t and Number or Rura			Zip Code) 21223
ie, Mal yle		Pamela Tazewe	ll-Daughte	er 111	North	Amity St	- Ant A	. Balti	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre	1-3	20a. Method of Disposition	-	20b. Place of Disp	osition (Name of matory or other pla	Amity St	ate 200	. Location - City or	Town, State
Deficient Pages Department of mportant: If it in y injury or or or or or or or or or or or or or		15 Surial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe				onal 6/2	4/05 B	altimor	e, Md
Dermit Depar Mpor Mpor Mpor		21. Signature of Funeral Service Li	rensee	P.	2. Name and Addr larch F/	ss of Facility H West			
_ 401 % 0		23a. Part 1. Enter the disease, or	monlinations that cause			ash Ave,			21215 Approximate
4.0		shock, or heart failure. List of Immediate Cause (Final	nly one cause on each li	ne.	•				Interval Between Onset and Death
Physiciar /Medica	_	disease or condition resulting in death)	a	a consequence of):	right	y Aste	y wis	rase	
Examine	r		500,000,000	2 33/103/43/103/51/).					
n =	ner.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	Due to (or as	a consequence of):					
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
e be exe sician a burial	cal Ex	resulting in death) East	Due to (or as	a consequence of):					
ficate physics the			d						
certif nding use a	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
death death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		⊒Ectopic pregnanc ⊒ Other (specify) _	:y		Month	Day Year
at the by the stache	Phys	9 🗆 Unknown	9□ Unknown						
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	b	Part II. Other significant condition	A	/	underlying cause gr	ven in Part I.			o the cause of death?
w requires is been signed should be	eted	(1)	r Myelo	4 /	reumo	nia	1 L Yes	2 □ No 3 🕱 P	robably 4 Dunknown
2 8 0	Completed	Chronic Ubs	tenctine	Pulmor	eary all	siase	24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
vital net victan: The lav certificate has rector, page 2	ပိ	25. Was dase referred to medical	itimal De	sease Di	abetis N	rellitis	1 □ Yes 2 🔀	No 1 ☐ Yes	s 250 No
vicial s certi	o Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Ott	26. Place of Death her: 4 \(\) Nursing Hor			20/44
ding Phys	-	27. Manner of Death	28a. Date of Inju	ry 28b. Time o	of 28c. Inju	ry at rk?	28d. Describe how i		эспу)
andin sath. or: Aft	atlo	1 Natural 5 Pending 2 Accident investiga	tion	y / ou/		Yes 2 □ No			
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of Inj	ury - At home, farm, st c. (Specify)	reet, factory, office	2	28f. Location (Stree City or Town, S	t and Number or R State)	ural Route Number,
pital ours a saral of		29a. Certifier 1 🗹 Certifying	Dhusisian Tasha hast	of any transition of a	4				
e Hos 24 hc a Fun	edical	(Check only 2 Medical E.	Physician: To the best xaminer: On the basis o and manner sta	f examination and/or in	Nestigation, in my	opinion, death occurre	ed at the time, date	and place, and dur	s stated. e to the cause(s)
To th within To th	₩e	29b. Signature and title of certifier			29c. Licens	se number	29d.	Date signed (Mont	th, Day, Year)
~1	1	P	HYSICIAN		D 5	7543		6-21-6	05
D 1		30. Name and address of person w	no completed cause of d	leath (Item 23a) (Type	Print)				
d-	101	PREET SANDH	v, mp 9	40 W. B	healis	RE SI	BALTI	MURE 1	no 21223
Regis	itate strar	31. Date filed (Month, Day, Year)	2005	No D. P					

		•	For State Registrar	State of	Marylan	•	artment of H rtificate of L		d Mental Hy	giene Reg. N2 (05	21342
	Physicia	an	1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic		Lois Magdali				U 02 T		June	27	2005	12:13 A M
	Examin	er	4a. Facility Name (If not institution	. 3	nber)		4b. City, Town, or Timoni		eath		nty of Death altimo	re
	Funeral		Stella Maris 5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 h				place (State or Foreign ntry)
	Director		213-36-6538	1 □ M 2KD F	69	Yrs.	Months Days	Hours M	Feb. 29	, 1936	Cour	Md.
put	3 1101		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or L	ocation					10d. Inside City Limits
Aaryla	Short	৳			1001011							1 ☐ Yes 2 ☐ No
at ytation 2.12.13-0030 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	Director	MD Ha	rford		For	est Hill 10f. Zip Code			10g. Citizen	of What Cour	
ath w	1 23e	ral	325 Donald Ci	rele			21050		? (Specify Yes or No	USA		
er de	Items The Chi	Funeral	11. Marital Status 1 □ Never Married 2 □ Mar	Armed Fo		.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	- 14. F	Race - Americ Black, White,	etc.
Irs aft	Po . Io	by	3 Widowed 4 □ Divorced	If Yes Giv	e ates:		1 ☐ Yes 2 🔀 No	Specify:		Spe	ecify: W	hite
2 Pot 2	cal E		15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	ation	working	16b. Kind o	f Business/In	dustry
thin 7	en "r Med	Completed	Elementary/Secondary (0-12)	college (1	-4or 5+)	life.	kind of work done of DO NOT use retired	ding most of	WOIKING			
M pe	ygien ner th	Col	12	4		Teac	her	40 Mathada	Nome /Cint Middle			Schools
be fil	ed oth	Be	17. Father's Name (First, Middle,						_{Name (First, Middle.} nevieve Na		name)	
hould	d Me mark matic	٦ ر	John W. Gri			19b. Maili	na Address (Street a		r Rural Route Numbe	<u> </u>	wn. State. Zid	Code)
and 2 s	Ith an				_					525770007	.62	
s 1 ar	item item		Kevin David Wh 20a. Method of Disposition	•	20b. F	lace of Disp	sition (Name of matory or other place	el l	Wayne, Pa.	20c. Location	on - City or To	own, State
Pages	nt: If nt: If iry or		1 — Burial 2 □ Cremation 4 □ Donation 5 □ Other (\$		סומוט		s Epis.Ce	1 .	30/2005	Kingsv	ville,	Md.
Dallillor Dermit. Pages	Departn Importe eny inju		21. Signature of Funeral Service	Licensee		2	2. Name and Addres	ss of Facility	chimunek T	linera	1 Home	of Bel Air
0 g	9 5 9 9		23a. Part1. Enter the disease, of	e-liel	les	61	O W. Mac	Phail 1	Rd., Bel /	ir, Mo	1. 21	()14
	ysician Medical		23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. <u>COLO</u>	aused the deat ach line. N CANCE or as a conseq	R	ter the mode of dyin	g, such as car	diac or respiratory a	rest,		Approximate Interval Between Onset and Death
E	caminer		Sequentially list conditions	b		112						
g	##	iner	Sequentially list conditions, if any, leading to infractions cause. Enter Underlying Cause (Disease or injury	- Dusits (or as a consuq	uence offr						
ou, be executed	physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	or as a conseq	Hence of):						
ate be ex	ician buria				o, us a sonooq	301.00 31).						
OX OO!	physis the	edical		d								
D. DOX	ned by the attending ph detached for use as the	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of d	I déath 3 l	☐Ectopic pregnancy ☐ Other (specify)	,			Date of delive Month	ery Day Year
OrdS, P.O. DC	s been signed b should be deta	by P	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the i	underlying cause giv	en in Part I.				the cause of death?
ecords law requires	as bee 2 sho	ompleted							24a. Was	an 24	b. Were auto	opsy findings available ompletion of cause of
The	ate ha								perfo	rmed?	death?	
	certificate has rector, page 2	BeC	25. Was case referred to medical examiner?	ai				the same of the sa	Death (Check only o	one)		
OT V Physic	his ce Il dire	To I	1 ☐ Yes 2 X No		npatient 2				ng Home 5 Resi			by HOSPICE
on o	n. After th funeral	lon:	27. Manner of Death 1 X Natural 5 ☐ Pendi	ing	of Injury h, Day Year)	28b. Time o Injury	Wor		28d. Describe	now injury oc	curred	
S S	tor: /	icat	3 ☐ Suicide 6 ☐ Could	igation I not be	of Injune - At h	ome farm et		Yes 2 □ No	28f Location (Street and Nu	mber or Run	al Route Number.
DIVISION el or Attending	ours after death. Insel Director: After this certifical in by the funeral director,	Certification:	4 Homicide determ	mined 200. Place buildi	ng, etc. (Specif	y)	reet, factory, office		City or To	vn, State)		
L To the Hospitel	within 24 hours a To the Funerel I completely filled	edical (29a. Certifier (Check only one) 1 Certifyi 2 Medice	ing Physicien: To the I Exeminer: On the b and man	best of my kno asis of examina ner stated.	owledge, dea tion and/or i	th occurred at the tin envestigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and date and plac	manner as s ce, and due to	itated. o the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifi	91			29c. Licens	e number		29d. Date sig	gned (Month,	Day, Year)
	1.1		1	1				4372	-5	6	127/0	25
	15		30. Name and address of person	MOOD 2200	DITT AND	257 37AT	TEV DD	ТТМОМТ Т	JM, MD 210	103		
	Sta	ate	DR. TARIQ MAR	32.8	gistrar's Signa	ature	LEY RD.	THONIC	רות בות בות בות בות בות בות בות בות בות ב	7.5		
¥.	Regist		JUN 2	8 2005 B	were.	K	cook					
DHME	17 Rev 1/2	2001				1						

DHMH 17 Rev 1/2001

JUNE 27, 2005 12:13 a.m.

LOIS WHEATLEY

	1	For State Registrar		artment of Health and Natificate of Death	Reg.	2005	21343
Physicia /Medica	n -	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	
Examine Funeral Director	er ⁴	a. Facility Name (If not institution, give str. 70	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y		PICY K placa (State or Foreigntry) MD
		Jsual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le				10d. Inside City Limi
or 28a-f	Director	MD NA Oe. Street and Number	Baltimo	10f. Zip Code	10g	. Citizen of What Cou	intry?
ital Hygiene. ed other then "natural", or Items 23s or 28s-f show event, Itte Medical Exeminer must bu notified at	20	701 Edmondson A 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	V € . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:	21228 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	U . S . A . 14. Race - Amer Black, White Specify: B	ican Indian,
then "natural the Medical Ex	Completed b	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+) 16a. Dece (Give life.)	edent's Usual Occupation a kind of work done during most of wo. DO NOT use retired)	rking R	b. Kind of Business/I oto-Root	er
al Hygiene. other then vent, I've Me	Be Con	12th grade 17. Father's Name (First, Middle, Last)	3yrs + M	laster Plummer 18. Mother's Name	me (First, Middle, Ma		Pervice
i and Mental	To B	John Webb Jr. 19a. Informant's Name/Relationship (Type)	e Print) 19b. Mail	Celest	e Garner		ip Code) 278
Health m 27 ther t		Celeste Brown-M	other 153	Davie Woods Dr	ive, Roa		id, NC
Department of H Important: If its any injury or of once.	ì	Marial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21 Sign via Funeral Service License	King Me	emorial Park 6/ 22. Name and Address of Facility 1368 Wabash Ave	-	Randallst	own, Md
hysician and Medical most and was as the burial-transit	ical Examin	23a. Fart1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final offsease or condition resulting in death) Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Ner the mode of dying, such as cardia	c or respiratory arres	π,	Approximate Interval Betweer Onset and Death
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□ Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
signed b	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.		accoluse contribute to s 2 □ No 3 □ Pr	the cause of death obably 4 Dunkr
aw requires is been sign 2 should be	Completed			as Place of D	24a. Was an autopsy perform 1 Yes 2:	ed? prior to death?	utopsy findings avai completion of cause 2 2 No
After this certificate ha funeral director, page	tlon: To Be	1 Yes 2 No 27. Man or of Death Natural 5 Pending	ospital: 1 Inpatient 2 ER/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ient 3 DOA Other: Nursing		nce 6 Other (Spe	cify)
no file nospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specity)		City or Town,		
24 hours 24 hours Funera stely fille	dical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemi	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla- investigation, in my opinion, death oc-	ce, and due to the ca curred at the time, da	use(s) and manner as ite and place, and due	s stated. e to the cause(s)
within To the comple	Mec	29b. Signature and little of certifier	n Laliha	29c. License number	29	od. Date signed (Mont	th, Day, Year)
1	1	30. Name and address of person who co	empleted cause of death (Item 23a) (Typ	oe. Print	Λ	10	

					Indelible Inkerpartment of its		_	Are Legibl o giene	9.
		1 - State Registrar			Certificate of	Death		Reg. N2. 0 0 5	21344
Physicia /Medic		Decedent's Name (First, Middle, Last) Gregory	Daniel		Warlic	k	2. Date of De Month June	Day Ye	3. Time of Death
Examin		4a. Facility Name (If not institution, give st	reet and number)	<u> </u>	4b. City, Town,	or Location of Death		4c. County of E	Death
		Johns Hopkins - Ba	yview		Balt:	imore		N/A	
Funeral Director		210-70-3330	7. Ag	e (In yrs. last birtho 45 Yr	Months Days		8. Date of Bi (Month, Di Octobe)	orth year) 9. r 20,1959	Birthptace (State or Foreig Country) MD.
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
ne Maryli Ba-f sho	ctor	MD N/A			timore				1 X Yes 2 □ No
ith with ti 23s or 2 ust be n	al Dire	943 Horner Lane			10f. Zip Code 2120	05		10g. Citizen of Wha	t Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: if item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other treumatic event, it s Modical Examitmet must be mailfied at once.	by Funeral Director	11. Marital Status 1: 1 XNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of the Yes, specify Cut 1 ☐ Yes 2 🛣 No		pecify Yes or No Rican, etc.)	o- 14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
in 72 ho n "netur	Completed	15. Decedent's Educi (Specify only highest grade	completed)	((ecedent's Usual Occu rive kind of work done fe. DO NOT use retire	during most of work	ring	16b. Kind of Busine	ess/Industry
y with	mo	Elementary/Secondary (0-12) 9 years	College (1-4or 5)+)	Never worl	ked		N/A	
Hyg othe /ent,	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle	e, Maiden Surname)	
Ald be Aenta rked tic ev	To B	Ambrose Warlick				Florence	e Leake		
short short		19a. Informant's Name/Relationship (Typ	e, Print)	19b. N	lailing Address (Stree	t and Number or Rui	ral Route Numb	per, City or Town, Stat	te, Zip Code)
and 2 patth 27 i		Ambrose Warlick	Fathe	r 943	Horner La	ane, Balti	imore, 1	MD. 21205	
Pages 1		20a. Method of Disposition 1	moval from State	cemetery,	isposition (Name of crematory or other pla L11 Memoria	ace)	29,2005	20c. Location - City Middle Ri	
permit. Departminimporte any inju	}	21. Signature of Funeral Service Licensed	1167	- le	22. Name and Addr Connelly	Funeral Ho	ome Of 1	Dundalk, P.	A.
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Ventr	the death. Do not not not not not not not not not no	enter the mode of dy			Dundlak, MC	Approximate Interval Between Onset and Death
ate be executed by sysician and be burial-transit and	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as	a consequence of)	Heart F	silure			days
or Attending Physicien: The law requires that the death certificate titer death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of Month	detivery Day Year
signed b	d by Pr	Part It. Other significant conditions cont	ributing to death b	ut not resulting in th	ne underlying cause gi	iven in Part I.			e to the cause of death? Probably 4 Unknown
	Completed						24a. Was	psy prior	autopsy findings available to completion of cause of
The	Col						1 Yes	ormed? death	n? Yes 2□ No
iclen: Th certificate rector, pag	Be	25. Was case referred to medicat examiner?	onital:			26. Place of Deat	h (Check only	опе)	
shysi this al dir	P_	1 X Yes 2 No 110 27. Manner of Death	spital:		MONE SEL DOA			idence 6 Other (S	Specify)
ling l After funer	o	1 Natural 5 Pending	28a. Date of Injur (Month, Day	ry Year) 28b. Tim Inju	ry Wo	ork?]Yes 2∐No	280. Describe	how injury occurred	
To the Hospitel or Attending Physicien: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Inju	ury - At home, farm c. (Specify)	, street, factory, office			Street and Number of wn, State)	r Rural Route Number,
ospitel of hours all unerei D ly filled i		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	cian: To the best	of my knowledge, d	eath occurred at the t	ime, date and place,	and due to the	cause(s) and manner	r as stated.
he H in 24 he Fi plete	Medical	(Check only 2 Medical Examinations)	and manner sta	ited.			red at the time,	date and place, and	due to the cause(s)
To T Con English	Σ	29b. Signature and title of certifier				se number		29d. Date signed (M	
/		beama	m		DZ	,8689		06/28/2))
5		30. Name and address of person who con	SM 2M		pe. Print) hns Ho	opkins	Bayun	com Mes	15 lical Cente
Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		7	t		
Registr	ar	JUN 2 8 2005	Manden s	K 60	golf.				

			. For	State of M	larylar				ealth and	•		egible.		
			1 - State Registrar		,		rtificate				Reg. 2. C	05	213	45
	Physici	an	1. Decedent's Name (First, Middle, I	_ast)						2. Date of De		Year	3. Time	of Death
	/Medic	cal	Eleanor M. We	ber)		4b Ciby T	Oum or	Location of Deat	June	25	, 200 punty of Dea	5 11:	<u>30a</u> [™]
	Examin	ier	Stella Maris	ive sheet and number	,				nium			ltimo		
	Funeral		Social Security Number 6	Sex 7. A	ge (In yrs.	last birthday) Yrs.	If Under 1		If Under 24 Hrs Hours Min.	8. Date of Bi	rth		thplace (State	or Foreign
	Director		213-28-5112 Usual Residence of Decedent		74	TIS.				5/3/	31		rylan	
	arylan show	5	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside	
	289-4	Director	Md Balt 10e. Street and Number	imore		Ro	seda]				10a Citiza	n of What Co		s 2 No
	th with		1315 Chesaco	Ave.				2123	37			USA	ountry :	
	er dea	uner	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.			spanic Origin? (S n, Mexican, Puerl	pecify Yes or No o Rican, etc.)			erican Indian, te. etc.	
20	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 ☐ Yes 2	No No	Specify:		S	pecify:	White	
9500-512	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28e-f show event, I're Medical Exaction must be notified at	Completed by Funeral	15. Decedent's (Specify only highest of			16a. Deced	lent's Usual	Occupa	tion uring most of wor	rkina	16b. Kind	of Business		
7	filed within Hygiene. Ither than '	dmc	Elementary/Secondary (0-12)	College (1-4or	5+)		shier		uning most of wor Recept		Δ+	torne	ey's (offic
פר	be filed ital Hygi id other evant, I	Be Co	17. Father's Name (First, Middle, Las			ou	5101		18. Mother's Nar				-y 5 (71110
yıand		To E	Bernard Groch							Andrze	· ·			
<u> </u>	C1 10 7 02		19a. Informant's Name/Relationship Ms. Kathleen S						nd Number or Ru norn Rd					20
e,			20a. Method of Disposition		20b. P	Place of Dispo		_		Date		tion - City or		
altimor	Pag nent ant: i		1 → Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spec	eify)		ly Ro	sary	Cen	ne. 6/2			dalk,	Md.	
g D	permit. Departr Importa any Inj once.		21. Signature of Funeral Service Lic	ensee	_0				k Peili Fun				1 01	0.00
		-	23a. Part1. Enter the disease, or on shock, or heart failure. List/on	mplications that cause	d the death	n. Do not ent	ZUI L er the mode	of dying	lalk Av , such as cardiad	or respiratory a	C 1 IIIO 1	re, M	Approximatinterval Be	
ı	Physician		Immediate Cause (Final disease or condition	PNEUMO									Onset and	I Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of);								
Ţ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uence of):								
/	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	2 2000000	unnes of):								
0/00/0	death certificate be executed e attending physician and ed for use as the burial-transit	dical E		Dao 10 (01 as	a consequ	derice or,								
00	intificating physics as the	Medi	IF FEMALE:											
POX	that the death certifics ed by the attending pl detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic preg				23d	. Date of deli	very Day	Year
	t the de by the ached	hysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9☐ Unknown	t time of de	eath 5	Other (spec	:пу)						
ָר ה	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the un	iderlying cau	se giver	n in Part I.				the cause of	
cords	been s	Completed								-		lo 3 Pr	obably 4 X	Unknown
Ė	The lay ate has bage 2	dwo									rmed?	prior to death?	topsy findings completion of	
		BeC	25. Was case referred to medical examiner?						26. Place of Dea	1 ☐ Yes		1 Ll Yes	2 🔀 No	
5	a thing	ို	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outpatient		Other	4 - Itaising in	ome 5 Resid			ity) HOSE	ICE
VISION	nding ath. r: Aftel e fune	atlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	M 200	. Injury a Work? 1 🔲 Ye	es 2 No	28d, Describe I	iow injury of	curred		
2	or Atta Iter des iracto n by th	ertification:	3 ☐ Suicide 6 ☐ Could not determined		ury - At ho	me, farm, stre	et, factory, o	office		28f. Location (S City or Tox	Street and N	umber or Ru	ral Route Nur	nber,
3	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	O	29a. Certifier 1X Certifying P	hysician: To the best	of my know	wledge death	geoured at	the time	date and place	and due to the	20.00(0) 000	4	-1-4-4	
	he Hoo in 24 h ha Fur pletely	edical	(Check only 2 Medical Exa	miner: On the basis o and manner sta	f examinat	ion and/or inv	estigation, in	my opi	nion, death occui	red at the time,	date and pla	ce, and due	to the cause(s)
	Tot Tot Com	Σ	29b. Signature and title of certifier				29c. L	icense				gned (Month		
			30. Name and address of person who	completed cause of d	leath (Item	23a) (Tuno 1	Print)	14	3725		6	1221	05	
	6		DR. TARIQ MAHM	OOD 2300	DULAN	EY VAL	LEY RI	D	TIMONIUM	1, MD 21	093			
	Sta Registra		31. Date filed (Month, Day, Year) JUN 2 8	2005 32. Registr	ar's Signat	H A	rate							

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JUNE 25, 2005

ELEANOR WEBER

Registrar

			State of Marylar 1- State Amend Items#19a&19b, per INI Registrar	nd / Depa F ,G845	artment of He Tificate of C	ealth and Ceath	Mental H	ygiene	5 21347
	Dhysici		Decedent's Name (First, Middle, Last)				2. Date of D	eath	3. Time of Death
	Physici /Medic		Glenn OGLA Ziegler				06	23 2	Year 09:46 M
	Examin	er	4a. Facility Name (If not institution, give street and number) UNIVEYSITY OF MAYY land		4b. City, Town, or 1	Location of De		4c. County of	of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 H Hours Mi		irth Day, Year)	Birthplace (State or Foreign Country)
	Director		578-66-7712 55	Yrs.			April		NOrfolk, VA.
	/land			ity, Town or Lo	cation				10d. Inside City Limits
	Man a-t sh	tor	MD	Baltimo	re				1X Yes 2 □ No
	th the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?
	23a 23a	ralD	2610 N. Patapsco Ave. #2D		21230			US	A
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Enantical must be notified an once.	/ Funeral	11. Marital Status 1 Never Married 2X Married 12. Was Decedent Ever in UArmed Forces? 1 Yes 2 No If Yes, Give	1	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 🛣 No	panic Origin? , Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	Black	- American Indian, , White, etc. Black
21215-0036	hours ural',	d by	3 Wildowed 4 Divorced Year or Dates:						
7	in 72 "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupat kind of work done du DO NOT use retired)	ion <i>Iring m</i> ost of w	vorking	16b. Kind of Bus	siness/Industry
77	with liene.	mo	Elementary/Secondary (0-12) Coltege (1-4or 5+) 1 yr.		k Clerk			Superfr	ach
ਰੂ	a filed of the other vent,	BeC	17. Father's Name (First, Middle, Last)	, ,,,		18. Mother's N	ame (First, Middl	e, Maiden Sumame	
<u>Ja</u>	uld be Venta rrked ric ev	To B	John Ziegler			Amanda	a Ziegl	er	
Maryland	2 sho and I is me	,	19a. Informant's Name/Relation 19a. Expl. 8(int)		ddress (Street ar				
	and lealth m 27 her tr		Eugenia Booze Zeigler/Wife		N. Pataps	co Ave		ltimore,	MD. 21230
Baltimore,	ges 1 it of H if ite or oth		20a. Method of Disposition 20b. 1 3 Pemoval from State 20b.	Place of Dispos cemetery, cren	sition (Name of natory or other place,)	Date		City or Town, State
Ë	t. Pa rtmen rtant:				ion Cem.	6-28		Clinton,	
Bal	Departing Department of the police of the po		21. Signature of Funeral Service Licensee	1	Name and Address				
			23a. Part I Enter the disease, or complications that caused the dea		217 9th.			_	Approximate
	Dhysisian		Immediate Cause (Final		or the mode of dying,	30011 03 00101	ac or respiratory	arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consection)	10515					1 year
	Examiner		A cut	e Ren	al Fail	11/0			2 days
	* *	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			are			0 9042
,	nd ransi	Examlner	Cause (Disease or injury that initiated events	rmon	11a				one Week
90	oe execian a	E	resulting in death) Last Due to (or as a consec	quence of):					
68760,	icate be executed physician and s the burial-transit	dical	d						
9 ×	leath certific attending p I for use as		IF FEMALE: 23c. If yes, outcome of pregn	ancy					
Вох	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	
P.O.	the d y the ached	ysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 0 9 ☐ Unknown 9 ☐ Unknown	20461 0	Other (Specify)				
٠ <u>٠</u>	res that the de signed by the a be detached f	by PI	Part II. Other significant conditions contributing to death but not rec	sulting in the ur	nderlying cause given	in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
ğ	w require been sig should b	ed b	Acute mycloid Leuk	emla			1 🗆	Yes 2□No 3	Probably 4X Unknown
Records,	aw re	plet					24a. Was		ere autopsy findings available
œ	The law cate has page 2	Completed					auto perf 1 ☐ Yes	ormed? de	ior to completion of cause of ath? □ Yes 2□ No
Division of Vital	ctor.	Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only		2700 22110
<u></u>	or Attending Physician: after death. Director: After this certific in by the funeral director.	٦ 1	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐	ER/Outpatient	t 3□ DOA Other	4 Nursing	Home 5 Res	idence 6 Other	(Specify)
Ü.	ling F	Certification:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe	how injury occurred	d
<u>s</u>	death death stor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be	omo form et		s 2 No	206 Lacation	(Chanad and Mumba	0
<u>≤</u>	lor A after Direct	ertii	4 Homicide determined 28e. Place of Injury - At h building, etc. (Speci	fy)	эет, тастогу, оптсе		City or To	wn, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Physician: To the best of my know	owledge, death	occurred at the time	. date and plac	ce, and due to the	cause(s) and man	ner as stated
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or inv	restigation, in my opir	nion, death oc	curred at the time	, date and place, an	d due to the cause(s)
	To ti Withi To ti	ž	29b. Signature and title of certifier		29c. License r	number		29d. Date signed	(Month, Day, Year)
)	_		MBdusty MO		1500	10		04/2	3/2005
	17		30. Name and address of person who completed cause of death (Iter 22 South Green S	m 23a) (Type, [Print) Dalh mo	M gr	0 8	1202	
*	Sta		31. Date filed (Month, Day, Year) 39. Registrar's Signa	ature					
	Registr	ar	JUN 2 8 2005	& Ana	A. a				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Paul Antoine Alburg 9:30 a. /Medical June 26. 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2502 Chelmford Drive Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year UNK Months 1 M 2 □ F Director 119 34 9248 67 South America Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Exertiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Crofton 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2111 2502 Chelmford Drive Funeral United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Exerting 1 ☐ Never Married 2 Married 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: ۾ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Consultant Cosmetics 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Edward Alburg Helen Ambel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Alburg 2502 Chelmford Drive, Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation __5 ☐ Other (Specify) Pinelawn Cemetery i07/01/2005 Farmingdale, New York 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Funeral Service, Inc. 21. Signature of Funeral Service Ligensee 410 Sterling Blvd., Sterling, Virginia 20167 23a. Part1. Enter to disease shock, or hart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** Schanges Cerl /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 2 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident Director: 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Leave the state of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DrOS 9942 address of pe son who completed cause of death (Item 23a) (Type, Print) 3 8926 WOUDYARD RD CLINTONMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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	. '		1 - For State Registrar	State of Mary		artment of H		Tental Hygiene		
	Physici /Medio		1. Decedent's Name (First, Mic		NS			2. Date of Death Month Da TUNE	2005 Year 2005	Time deputy
	Examin		4a. Facility Name (If not institut		ITAL	4b. City, Town, or	Location of Death	W 70 40	County of Deat	YIRE
	Funeral Director		5. Social Security Number 223-10 - 9215	6. Sex 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birt	hplace (State or Foreign unitry) GA
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. Cour	altimore. 100	c. City, Toyn or Lo	cation US	nu)n			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	Funeral Director	10e. Street and Number 9057 Allens	swood Rd	1	10f. Zip Code	33	10g. Ci	tizen of What Co	untry?
36	72 hours after death with the Maryland natural', or lieme 23a or 28e-f show disal Examinar must be notified at	by Funera	11. Marital Status 1 Never Married 2 M 3 Widowed Divorce	12. Was Decedent Ever Armed Forces? arried 1 Yes 2 □ No		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
1215-0036	⊆ 9	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	ent's Education hest grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired;	uring most of work	ing 16b. K	Kind of Business/	Industry
Maryland 21	ould be filed with Mental Hygiene. arked other thar atic event, the	To Be Co	17. Paner's Name (First, Middle Fer Gar	e, Last)	<u> </u>	r pente	18 Mother's Name	e (First, Middle, Maider &	Sumame)	71011
	1 and 2 should Health and Meniem 27 le marketther treumatic		19a. Informant's Name/Relation Dean A. AdK	inship (Type Print)	19b. Mailir 905	ng Addres Street a	wood Rd	Rundall	or Town, State, 2 Stown,	RD 21133
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Crematio 1 Donation 5 Other	n 3 Removal from State	Ob. Place of Dispo cemetery, prer	sition (Name of natory or other place	Jerg 7/2	20c. L.	ocation - City or	Town, State
Balt	permit. Pag Department Importent: I any injury o		21. Ignature of Funeral Service	e Lichsee Helene	3(Name and Address	of Greek	e Funera	1 Servi stown, 1	LD 21133
	Physician		23a. Part i I Inter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition	or complications that caused the dist only one cause on each line.	death. Do not ent	er the mode of dying	, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):					
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8760,	cate be executed by sicien and the burial-transit		resulting in death) Last	d.	nsequence of):					
O. Box 6	ath certific thending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of produced in the state of the sta	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year
0	uires that the de signed by the a Id be detached t	by	Part II. Other significant cond	itions contributing to death but not	t resulting in the u	nderlying cause give	on in Part I.	23e. Did tobacco		the cause of death?
i Records,		Completed						24a. Was an autopsy performed?	death?	topsy findings available completion of cause of
Vital	Physiclen: Th this certificate ral director, pag	To Be (25. Was case referred to mediexaminer?	Hospital: \ a	2 ER/Outpatien	t 3□ DOA Othe	· ·	me 5 Residence	6 □Other (Spe	city)
ion of	ding Pł n. After tł funeral		27. Manner of Death Natural 5 Pend 2 Accident investigation	28a. D te of Injury	28b. Time of Injury	28c. Injury Work M 1 \(\sum Y	at ? ′es 2 □ No	28d. Describe how inju	ry occurred	
Division	el or Attending P s after death. N Director: After t od in by the funera	Certification:	3 Suicide 6 Coul 4 Homicide dete	ld not be mined 28e. Place of Injury - building, etc. (Sp.	At home, farm, str oecify)	eet, factory, office		28f. Location (Street ar City or Town, State		ral Route Number,
	To the Hospitel or Attent within 24 hours after deati To the Funerel Director: completely filled in by the	Medical (29a. Certifier 1 Certific (Check only 2 Medic one)	ying Physician: To the best of my al Examiner: On the basis of exar and manner stated.	knowledge, death mination and/or inv	n occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the cause(s ed at the time, date and) and manner as I place, and due	stated. to the cause(s)
) /	Tor With	Σ	29b. Signature and title of certi	/ lin (0	29c. License	1733	3 JyN	te signed (Month	7. Day, Year) , 20 EJ
6			30. Name and address of person	on who completed cause of death	(Item 23a) (Type	ACTO (4021	133		
ľ	Sta Registr		31. Date filed (Month, Day, Yea	ar) 32. Registrar's 3 JUN 2 9 2005	ignature	Sperk	,			

			For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of I		d Men		ne . No 2 0 0 5	5 213	350
			Decedent's Name (First, Middle, I	Last)					Date of Death		3. Time o	of Death
	Physici /Medic		Louis J.	Allegra				Ju	Month ne 2	Day Yea 200		A^{M}
	Examin		4a. Facility Name (If not institution, g	give street and numbe	r)	4b. City, Town, o	or Location of D	eath		4c. County of De	ath	
			Cherry Lane Nu	sing Home		Laurel				Prince (George's	•
	Funeral		Social Security Number 6		Age (In yrs. last birthday,	If Under 1 Year Months Days			Date of Birth Month, Day, Ye	9. E	Birthplace (State Country)	or Foreign
	Director		185-32-4156	1\(\)M 2□F	63 Yrs.					1941 Per		
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside C	City Limits
	daryl f sho	ō	MD Anne Ar	rundel	Laurel							s 2,∏No
	28e-	Director	10e. Street and Number	- dilder	Eddici	10f. Zip Code			100	. Citizen of What		
	With With		250 Sharptown So	outh			20724			USA	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	ns 2%	Funerai	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.			? (Specify	Yes or No-		nerican Indian,	
(0	riter o	Fun	1 ☐ Never Married 2X Married	Armed Forces	?]No 1960	Was Decedent of I		uerto Rica	n, etc.)	Black, W	nite, etc.	
8	el', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	: -1964	1 □ Yes 2XXXNo	Specify:			Specify:	White	
21215-0036	be filed within 72 hours after death with the Maryland at Hygiene. All Hygiene and the then "natural", or Items 23a or 28e-f show other then "natural", or Items 23a or 28e-f show event, the Markeal Event and real the indiffed at	Completed	15. Decedent's (Specify only highest			dent's Usual Occup		working	16	b. Kind of Busines	s/Industry	
2	within iene. then "	npie	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NOT use retire	d)					
2	filed w Hygier other th	S	12th	Ø	Inte	lligence				Security	<i>T</i>	
Maryland	be fill od otl	Be	17. Father's Name (First, Middle, La	-						iden Sumame)		
3	s 1 and 2 should be I Health and Mental Item 27 is marked other treumatic ev	၉	Carmen Allegra		405 14:37				Sciali		7.0.11	
Mai	d 2 st h and 7 le r treur		19a. Informant's Name/Relationship			ng Address (Street					, Zip Code)	
a,	es 1 and 2 of Health I item 27 I		Marguarita Allec	jra/wire	25U 20b. Place of Disp	Sharptown sition (Name of	n South	l, Lat		D 20/24 c. Location - City	or Town State	
Baltimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3		e cemetery, cre	matory or other pla						-
臣	it. P.		*4 □ Donation 5 XOther (Spe 21. Signature of Funeral Ser∳ice Lice	the second second second	-	y Cemete: 2. Name and Addre	-	30/		Cherry H		
Ba	permit. Pages Department of I Important: If its any injury or of		1 GZ SCP			313 Talbo					•	Α.
			23a. Part1. Enter the disease, once shock, or heart failure. List pr	mplications that cause by one cause on each	ed the death. Do not en line.	ter the mode of dyi	ng, such as car	diac or res	piratory arrest	,	Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	, Met	astatic Co.	lon Cance	r				Onset and	Death
	/Medical Examiner		resulting in death)		as a consequence of):							
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	D	ngestive Hea	art Failu	re					
	ted nsit	nine	Cause (Disease or injury	20010 (012	as a consequence ory.							
	axecu and al-tra	Examine	that initiated events resulting in death) Last	c Due to (or a	is a consequence of):						_	
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	dicai E		4								
687	ificate g phy as the	- w :		- u.								
Box	death certifice attending ph d for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		7e				23d. Date of c	lelivery	
	death e atte	icla	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant		⊒Ectopic pregnanc ⊒ Other (s <i>pecify</i>) _	у			Month	Day	Year
P.0	that the digital the digital the detached	hys	9 ☐ Unknown	9□ Unknown		·						
	S C 0	by F	Part II. Other significant condition:	s contributing to death	but not resulting in the	inderlying cause giv	ven in Part I.		23e. Did tobac	co use contribute		
Records,	w require been sig should b								1 🗌 Yes	2 ^X □No 3□	Probably 4 🔲	Unknown
ecc	aw law	ompieted							24a. Was an autopsy	24b. Were	autopsy findings o completion of c	available
E .	The ate h page	Con							performed 1 □ Yes 2X	d? death	? es 2. X No	
Vital	Phyeicien: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?					Death (Ch	eck only one)			
of	Physicie this cert al direct	2	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpa	A	III JU DOA				e 6 Other (S)	pecify)	
n c		lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, E	jury 28b. Time of Injury	Wo		28d.	Describe how	injury occurred		
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Division	iel or Attenc s after death sl Director: ed in by the	Certification	4 ☐ Homicide determine	building,	etc. (Specify)	reet, factory, office			City or Town, S		iurar rioute reur	1001,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier	Physician: To the best caminer: On the basis and manner:	st of my knowledge, dea of examination and/or in stated.	th occurred at the tinvestigation, in my o	me, date and pl opinion, death o	lace, and o	lue to the caus the time, date	se(s) and manner and place, and d	as stated. ue to the cause(:	s)
	To the within 2 To the complet	Š	29b. Signature and title of certifier	11/	-	29c. Licens	se number		29d.	Date signed (Mo	nth, Day, Year)	
	1//		1/mul	Hele		0053	235			June 27,	2005	
	り		30. Name and address of person wh	no completed cause of	death (Item 23a) (Type	Print)						
	1		Darryl Hill		timore Aver			2070)7			
	Sta Registr		31. Date filed (Month, Day, Year)	UN 2 9 200:	strar's Signature	& Apar	E)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BROWN UDDIE 7:15 Am 2005 ଥ ୫ JUNE /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE. FUTURE NURSING CARE Home. 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** Days Months 241-12-875 1 ☐ M 2 KF Director Usuel Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after death with the Marylend 10a. Stete 10d. Inside City Limits 10c. Gity, Town or Location Depertment of Health end Mentel Hygiens "returns are usern with the Maryle Important: if item 27 is marked other than "naturel", or items 23e or 28e-f ehov eny injury or other traumatic event, the Madical Examinet must be notified at once. Baltimore 1 ☐ Yes 2 ☐ No **Funeral Director** town 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 200 No
If Yes, Give
Year or Detes: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify. ģ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Kind of Bull Heal Elementary/S condary (0-12) College (1-4or 5+) rses 19b. Mailing Address (Street and Nur Plationship work Plate Jube 20b. Place of Disposition (Name of cemetery, cremator) or other p 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice Lichns Kundalls MD 21133 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical . HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR Examiner DISEASE Due to (or es e consequence of): Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MELLI DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DEMENTIA. 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 21XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No aftar death. 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 🗆 Homicide within 24 hours aft To the Funeral Di completely filled in 1. crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edicai 29d. Date signed (Month, Day, Yeer) 296. Signard and title of certifier 29c. License number 2 SICIAN 2005. 42723 SMUL OLD COURT ROAD, SUITE 303 5310 end address of person who completed cause of death (Item 23a) (Type, Print) RANDALLSTOWN HARISH 32. Registrer's Signature 31. Date filed (Month, Day, Year) State Heren J. Sperle Registrar

DHMH 16 Rev 6/95

Dwight Burgess Unknown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04172 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar crn Reg. No. 200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:45 DONNEL 19 WIGHT JURGESS June 2005 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1011 McKean Avenue N/A Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. 5. Social Security Number last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 □ F 220-64-308 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ral', or itema 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Completed by Funeral Director MARVLAND 10g. Citizen of What Country? 10e. Street and Number 0 Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 12 HH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be 2 AMOS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and pepartment of Health ar Important: If Item 27 is any injury or other traugnos. 915 BALTIMORE MD. 21228 FATHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06-28-05 DWING FARRISON FOREST * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN JR. FUNERAL N. FULTON BALTO. AVE 28a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Swole Inhalat Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit requires that the death certificate be executed signed by the attending physicien and deep detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No 24a. Was an autopsy performed? 1X Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 1 XYes 2 ☐ No 2 ER/Outpatient 3∏ DOA this 28a. Date of Injury
(Month) Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification: After 1 Natural
2 Accident
3 Suicide Found A 5 Pending Victim of a house death. 1 Tes investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) [OII McKern #VC 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person

npleted cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature

OCME

June 19, 2005

9 2005

State of Maryland / Department of Health and Mental Hygiene Reg. N.2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last. 2. Date of Death Day Year Month **Physician** JOHN 3:17 BERANEK 17/ 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Univ. of Maryland Medical Syst Baltimore n/a | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10-22-34 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5, Social Security Number **Funeral** 1**X** M 2□ F 215-30-2414 70 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at MD. **Baltimore** 1 TYRS 2 NO Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5827 Comstock Avenue 21206 U.S.A. or Items 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Modical Examplem 2010. Black, White, etc. 1 Yes 2 No
Il Yes, Give
Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Engineer Westinghouse Corp. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rudolph Joseph Beranek Marrie Virginia Janssen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carrole A. Beranek (wife) 5827 Constock Avenue-Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cardens of Faith Cem. 6-21-05 Baltimore, Maryland A □ Donation 5 □ Other (Specify) E.F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11750 Belair Road-Kingsville, Maryland 21087 E.F. Lassahn per dyr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 25 hr 2 Immediate Cause (Final Intracerebral Hemorrhage 26 ... Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-trans that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 99 Coronary Artery Disease Yes 2 No 3 Probably 4 Unknown Stroke 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No Hypertension Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) HospitaXX Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes X2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After XXX Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide 24 hours a Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year)

State Registrar

31. Date liled (Month, Day, Year)

29b. Signature and title of certifier

Alexander H.

32. Pegistrar's Signature

don

MD

29c. License number

June 23, 2005

P15804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander H. Papangelou, MD 22 S. Greene St., Baltimore, Md 21201

	1 - For State Registrar	State of Maryla		artment of He			iene	~ ^
	Decedent's Name (First, Middle, L.	ast)				2. Date of Deat	h 200;	3 Time 3 Date
Physician		George P.	Breite	enbach		Month June	Day Ye 22. 200	2 F2 D M
/Medical Examiner	4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, or L	ocation of Death	<u> </u>	4c. County of D	
	Lorien Nursing H	ome & Rehab. (tr.	Baltime	ore City		N/	A
Funeral		Sex 7. Age (In yi	s. last birthday,			8. Date of Birth (Month, Day,	9	Birthplace (State or Foreigr Country)
Director	215-30-8130	1₽ M 2□ F 70	Yrs.	Monuis Days	Hours Will.	Aug. 27		Pennsylvania
neturel; or items 23a or 28e-f show diest Enstraint mast be mulified at eted by Funeral Director	Usual Residence of Decedent 10a, State 10b, County	100	City, Town or L			J		
shove and a			City, TOWN OF L	ocation	D 11-			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
e. An "neturel; or Items 23a or 28e-f show Medical Enartimetrmatte multiput at npieted by Funeral Director	Maryland Ba	ltimore		1	Dundalk			
Dir				10f. Zip Code		10	og. Citizen of What	Country?
r ttems 23	3415 Wallford		11.6	M B - 1 - 1 (1)	21222	'f- VN-	United :	
nue me	11. Marital Status	12. Was Decedent Ever in Armed Forces?	0.5.	Was Decedent of His If Yes, specify Cuban,	panic Origin? (Sp , Mexican, Puerto	ecity Yes or No- Rican, etc.)		merican Indian, /hite, etc.
by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	
a pa	15. Decedent's		16a Dece	dent's Usual Occupat	ion		16b. Kind of Busine	White
t, the Medical E	(Specify only highest g	rade completed)	(Give	kind of work done du DO NOT use retired)	ring most of work	ing	TOD. KING OF DUSING	553/110ustry
omp	Elementary/Secondary (0-12)	College (1-4or 5+)	C+	ool Works	20		C+	1 7 3
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atic even	George Breite	nhach			Christi	ne Kline		
eumetic ev	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street an				e, Zip Code)
other treumetic	Phyllis Breitenb	ach (Wife)		5 Wallford				
othe	20a. Method of Disposition		. Place of Disp	osition (Name of	! 1		20c. Location - City	
	ty□ Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec			matory or other place)		/2005	M ! 3 3 1	2.1
any injury or	21. Signator of Funeral Service Lic	,110		1 Mem. Gd: 2. Name and Address		/2005	Midale	River, MD
any ir	V/2 + 12 1		Dı	ıda-Ruck Fı	uneral H			
	23a Part1. Enter the disease of co	mplications that caused the de		922 Wise 7				21222 Approximate
	shock, or heart failure. List only Immediate Cause (Final	y one cause on each line.	M	N				Interval Between Onset and Death
ician dical	disease or condition resulting in death)	a. 25 KD	onri)				
iner		Due to (or as a cons	equence of):					
e le	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):					
ial-transit	if any, leading to immediate Cause (Disease or injury							
burial-transit	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):					
in pri		d —						
edi i								
etached for use as the Physician/Med	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of prec		7-			23d. Date of	delivery
d for	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fe 4□Pregnant at time o		□Ectopic pregnancy □ Other (specify)			Month	Day Year
tached	9 Unknown	9□ Unknown						
0		contributing to death but not r	esulting in the u	inderlying cause given	n in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
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age 2 should ompieted						24a. Was an		autopsy findings available
page 2						autopsy	y prior ned? death	to completion of cause of a
0 ()					OC Plans of Post			/es 2□No
B rect	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie			h (Check only one	a) nce 6 □Other(5	Second 1
		28a. Date of Injury	28b. Time o		at Wursing no	28d. Describe ho		вресту)
funer	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Year)	Injury		es 2 □No			
in by the funera	3 Suicide 6 Could not	d 286. Place of Injury - Al	home, farm, st	reet, factory, office				Rural Route Number,
d in b	4 Homicide	building, etc. (Spe	icify)			City or Town,	. State)	
ai C	29a. Certifier X Certifying F	Physician: To the best of my k	nowledge, deal	h occurred at the time	, date and place.	and due to the ca	use(s) and manne	r as stated.
pletely fill edicai	(Check only 2 Medical Ex-	aminer: On the basis of exame and manner stated.	ination and/or in	vestigation, in my opin	nion, death occur	ed at the time, da	ite and place, and	due to the cause(s)
completely filled in b	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (M	onth, Day, Year)
	No. MD			D57	727	6	127 05	
	30. Name and address of person wh	o completed cause of death (I	tem 23a) (Type	Print) .	^ - 1			
-1	Navardii RI	VANTE TOO	9 I	rahland	Aren	ent. K	tmos	21206
State	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	wyw 40	, 110,0		J., 10 W.	
Registrar	JUN 2 9 2	005	K L	Also .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 18:48P Allen Eugene Brinkley June 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince George's Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 26,1934 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Days Hours Min. Yrs. 579-48-4832 **Director** Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marytand 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Itams 23a or 28a-f show Itu Medical Exami tor in usi be notified at 1 Yes 2 No Maryland Prince George's Clinton Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8608 Mimosa Avenue 20735 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1∑Wes 2 □ No 1953— If Yes. Give Year or Dates: 1957 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. 2^{College (1-4or 5+)} Elementary/Secondary (0-12) Programmer Dept. of Commerce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event sonce. Be James Brinkley Nellie Wright 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Brinkley (Wife) 8608 Mimosa Avenue Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemi 2005 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature if Funeral Sarvice Licensee Lee Funeral Home, Inc. 22. Name and Address of Facility 6633 Old Alexandria Ferry Road Clinton, MD 20735 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCARDIAC Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HEART DISEASE HEROSCLEROTIC burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARDIOGENIC SHOCK 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown TRUCTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? PAILURI 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6-22-05 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) LEE, M.P. OLD BRANCH AVENUE 32. Registre's Signature State Registrar

		-	For State	State of	Marylan	-	artment o			and Me			000	p.co.		
N	0		Registrar 1. Decedent's Name (First, Middle, La	ist)			imodic	<u> </u>			2. Date of Dea		2 0 0	5	9: Time of D	5,6
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	Funeral			Sex 7. 1 ☐ M 2 🂢 F	. Age (In yrs. i	last birthday) Yrs.	If Under 1 Months E	Year Days	If Under 2 Hours		8. Date of Birtl (Month, Day June 27	h v, Year)	12 1	9. Birthp	lace (State or F ltry) York	oreign
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Mary	and and sm		19a. Informant's Name/Relationship Kenneth K. Burne		_						Route Numbe			23	Code)	
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BURNETT, FLORENCE

		•	For State Registrar	State of Maryland / De	epartment Certificate			and M		giene Reg. N <mark>2</mark> 0	105	21357
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	/Medic Examin		4a. Facility Name (If not institution, gives UNIVERSITY OF MA	street and number)	4b. City,		Location of		M D	· T	inty of Death	
	uneral		Social Security Number 6. Sex		day) If Under		If Under: Hours 21	24 Hrs. Min.	8. Date of Birt. (Month, Day May 12,	v, Yeer)	Cour	place (State or Foreign htry) yland
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0036 hours afte	urel', or l	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2	2₹ No	Specify:			Spe	ocity: b1	ack
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			30. Name and address of person who come MADHAVI SANGE			ARY	LANI) , E	BALTIN	NORE	, MD	
	Sta Regista		31. Date filed (Month, Day, Year) JUN 2 9 201	32. Registrar's Signature	hearth o							

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December Name (First Motion, Later) December Name (First Motion, Maletina)			for State Registrar	State o	of Marylar		artmen rtificat			and M	•	giene Reg. No.		
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F 11140547	Tol	Σ	29b. Signature and title of certifier				290	. License	number					
													2005	
30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Dr. Ana Rubio 111 Penn Street Baltimore, MD 21201				withlefed can			•	Ba1	timor	e. M	D 2120)1		
State State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				32. F					2	-,		-		

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Per Phy G844 Certificate of Death Reg. No. 1 21360 State Registrar Amend Item #1 Per Phy C844 1. Decadent's Name (First, Middle, Last) 2. Date of Death Month Arthur Campbell **Physician** 2005 JUNE 23, 1:05 PM /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Pay, Yea 9. Birthplace (State or Foreign Country) Engmen 7. Age (In yrs. last birthday, **Funeral** 1 M 2 F Days Hours Min -30.397 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Baltinone 1 188 2 No MI Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21207 380 USA 5 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Defes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Latino 1 Yes 2□ No Specify: Latino 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 2 should be fill and Mental H Be William eni etta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 11454 permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau Stewart Lung Iverspors MD 20a. Method of Disposition obell 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 DrBurial 2 □ Cremation 3 □ Removal from State Fur est 105 ` 4 ☐ Donation 5 ☐ Other (Specify) sour son Anaid Ger 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Credene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Le Bath MOZIZZ Approximate Interval Between Onset and Death Immediate Cause (Final Physician UNKNOWN a PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PARKINSON'S DISEASE, PAGET'S DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) autos JUNE 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELECIA SANTOS, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

name known to Physician

			Chate of Manyland / Department of Health and	•		•	
			State of Maryland / Department of Health and	Mental			
			Registrar Certificate of Death		Reg. No	°2005	21361
П	Physici	an	1. Decedent's Name (First, Middle, Last)	Month	of Death h Da		6. Time of Death
	/Medic	al	Willie S. Chandler JR	Jui			11:35 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea About 1 Boul himsel Balhimsel	atn	40	c. County of Death	n
	-		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr	S. 8 Date (of Birth	9 Rid	hplace (State or Foreign
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	nylan how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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	ith th	Oire	10e. Street and Number		10g. C	itizen of What Co	untry?
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36	rs aft	y F	1 Never Married 2 Married			Specify: Q	2116_
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Maryland	2 sho and is ma		19a. Informant's Name/Relationship (Type, Print)	Rural Route N	umber, City	or Town, State, Z	lip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Detty Kencher 600 Lavery A	ve	Sult	-c.m.	7. 41337
Baltimore,	Pages 1 nent of H int: if ita iry or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		_ocation - City or 1	
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Bal	permit. Pages Department of H Important: If its any injury or of		21. Signature of Furleral Toles Licinities 22. Name and Address of Facility	7 Sea	wit i	D. P.	batto mo
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a		e Co	25. Was case referred to medical 26. Place of De	1 U Y) 1 ☐ Yes	2 No
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			Havite Pendli, MD RES-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Havithe Pendli, MD &401, West Bel	lvede	ere A	venue,	Baltinge-M
F	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
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DHMH 17 Rev 1/2001

Pt. thousan as Willie Chandles

			For	State o	f Maryla				d Mental Hy	ygiene		
			1 - State Registrar			Ce	rtificate of	Death	1	Reg. No.	2005	21362
	Physici	an	Decedent's Name (First, Middle, Las	,					2. Date of D	Day		5. Tithe of Death
ı	/Medic	al	Wallace 4a. Facility Name (If not institution, give	H.	mhor)	Camr	be11 4b. City, Town,	or Logation of D	June	26	2005 County of Death	10:30 A M
	Examin	er	Gilchrist Hospice			Δ.		Wson	eatn	40.	Baltir	nore
	Funeral		5. Social Security Number 6. Se	x		s. last birthday)	If Under 1 Year	If Under 24 I	Irs. 8. Date of B	irth		place (State or Foreign ntry)
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	the h	rect	Maryland Baltimo:	re		Towson	10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
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	death	Funeral Director	11. Marital Status		edent Ever in 1	U.S. 13.	1	Hispanic Origin?	(Specify Yes or N		14. Race - Ameri Black, White	
õ	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or terms 23a or 28a-f show that the Medical Examinar must be notified at		1 Never Married 2 Married	1 ∐Yes If Yes, Giv	2 (1) No		1 Yes 2 No		20110 1 110011, 010.7		Specify:	
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and	al Hyg	Bec	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middi	e, Maiden	Sumame)	
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банттог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertial Hygiene. Department of Health and Mertial Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ampringer or other traumatic event, the Medical Examinat must be notified at once.		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen 		Di		Cremator	The second secon	27/05			Maryland
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Q	tificate ig phy as the	edi										
gox	death certifi e attending id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregr		⊒Ectopic pregnanc	ev.		2	3d. Date of deliv	•
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D 01	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	of 28c. Inju	iry at ork?	28d. Describe			
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_	pital ours a beral (O	29a. Certifier 1 Certifying Ph	vsician: To the	best of my kr	nowledge, deat	th occurred at the t	ime date and pi	lace, and due to the	e cause(s)	and manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	(Check only 2 Medical Examone)	tiner: On the b	asis of examir ner stated.	nation and/or in	nvestigation, in my	opinion, death o	occurred at the time	, date and	place, and due t	o the cause(s)
	To th within To th comp	Me	29b Signature and title of certifier	//	/		1	se number			signed (Month,	
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1	71		30. Name and address of person who		se of death (Ite	em 23a) (Type	Print)	-	12-11	,		2 (1 = 1 :
	0		Jason Black 31. Date filed (Month, Day, Year)					211	. Ba /to	more	· u,D.	11207
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9 2	กกร เรีย	ogiatiai s aigi	H A	and I					
DH	MH 17 Rev 1/2	-100	3 0 411 4 0 5	000	MUSA.	es 19						

				rtment of Health and Mental tificate of Death	Hygiene Reg. No. 2005 21363
	Physici	an	1. Decedent's Name (First, Middle, Last) Myrna Loye Conner Carter	2. Date (Month June	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 6007 Cable Ave.	4b. City, Town, or Location of Death $Suit1and$	4c. County of Death Prince George
	Funeral Director		5. Social Security Number 253-62-4780 6. Sex 1 M 2 F 64 Yrs.	Months Days Hours Min. 8 Date of Man. Man.	of Birth b, Ray, Year 194 George gia
	e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Prince George's Suit.		10d. Inside City Limits 1 □ Yes 2 ∰No
	with the	al Director	10e. Street and Number 6007 Cable Avenue	10f. Zip Code 20746	10g. Citizen of What Country? U.S.A.
920	be filed within 72 hours after death with the Maryland that Hygiene. ad other then "neturel", or Items 23e or 28e-f show event, the Medical Esartinar must be troilled at	by Funerai	1 Never Married 2 TV Married 1 TYes 2 TVNo	Vas Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc □ Yes XXNo Specify:	or No- 14. Race - American Indian, Black, White, etc. Specify: White
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and	2 should be filed within and Mental Hygiene. is marked other then eumetic event, I'm M	Be	17. Father's Name (First, Middle, Last) James Omar Conner	18. Mother's Name (First, M Dallas Barf	
Maryland	s 1 and 2 should f Health and Men item 27 is marke other treumetic	7 2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	g Address (Street and Number or Rural Route N Cable Avenue Suitlan	lumber, City or Town, State, Zip Code)
Baltimore, I	00		20a. Method of Disposition 1 [XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, crema	sition (Name of Date natory or other place) June 25, tion Cemetery 2005	20c. Location - City or Town, State Clinton Maryland
Balt	permit. Page Department Importent: If any injury o		Hances packed Juling Moi435 6		ry Road Clinton, MD 20735
	Pnysician /Medical Examiner		resulting in death) Due to (or as a consequence of):	er the mode of dying, such as cardiac or respirat	ory arrest, Approximate Interval Between Onset and Death
8760,	cate be executed oblysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate caus. Enter Ur darphing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of):		
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Vital Records,	The law requir ate has been si page 2 should l	Completed by		24a.	Was an autopsy findings available prior to completion of cause of death? Yes 2 □ No 1 □ Yes 2 □ No
Vital	sicien: certifica rector, I	Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check	only one) Residence 6 □Other (Specify)
n of	Attending Physicien: r death. ector: After this certific by the funeral director,	ion: To	27. Manner of Death 1 PNatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	cribe how injury occurred
Division	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director. After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		tion (Street and Number or Rural Route Number, or Town, State)
	ne Hospite 124 hours ne Funerel letely filled	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatly and manner stated.		
	To th withir To th comp	Me	29b. Signature and title of certifier ld 14555 Suguen v.	29c. License number D28079	29d. Date signed (Month, Day, Year) TUNE 23, 200 S
	Oj		30. Name and address of person who completed cause of death (Item 23a) (Type, Francine Higgs-Shipman, MD 117	00 Beltsville Dr. 1	Beltsville, Md.
	St Regist	ate rar	31. Date filed (Month, Day, Year) N 2 9 200 Registrate Signature	Sperti	

			1 - For State Registrar		epartment of Health and I	Mental Hygie	000-
	-		Decedent's Name (First, Middle, Landson L			2. Date of Death	3. Time of Deam
	Physici /Medi		WAITER Coffie	10		June a	Day Year 21:57 M
	Examir		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Union MEMORIA	HUSPITAL	BAITIMON E		Ma
	Funeral Director			Sex 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth (Month, Day, You SEPKMBER	ear) 9. Birthplace (State or Foreign Country) 2/93 2-C
	land		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
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	r dea	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Dican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	Y.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify
8	hour	ed b	15. Decedent's E	Year or Dates:	Decedent's Usual Occupation	16	Black b. Kind of Business/Industry
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or itema 23a or 28a-f show he Medical Examinar mat be notified at	Completed by Funeral Director	(Specify only highest gr	rade completed) (Give kind of work done during most of work ife. DO NOT use retired)	king	o. And of business/moustry
212	d with giene. rr than	E	Elementary/Secondary (0-12)	College (1-4or 5+)	instruction WUXX	C	enstruction
	ould be filed Mental Hygir arked othar atic event.	Bec	17. Father's Name (First, Middle, Las			ne (First, Middle, Mai	iden Sumame)
ylai	Ment Ment arkec	2	NEPOLION CO	Hield	Lucy	MCCORNIC	C/C
Maryland	sh and and and and and and and and and and		19a. Informant's Name/Relationship		Mailing Address (Street and Number or Ru		
-	1 and Health am 27 ther tr		NOAM! CLUdy	20h Place of F	10 N. Calverd 3		1610 0118
Ö	Pages ient of H int: If its		20a. Method of Disposition Burial 2 Cremation 3	cemetery	crematory or other place)		. Location - City or Town, State
altimore	it. Parrimer ritant		 4 ☐ Donation 5 ☐ Other (Special Service Lice 21. Signature of Funeral Service Lice 	ity) ///F·C	PKME / CEMETERY 7/1 22. Name and Address of Facility	105	DAITIMONEMD
Ba	permit. Pages 1 and 2 Department of Health s Important: If itam 27 ti any injury or other tra once.		10/1	eth	1189 N. CATOLINE O		
			23a. Part1. Enter the disease, or con	nplications that caused the death. Do no	t enter the mode of dying, such as cardiac		Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		C ,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a consequence of		taictin	PINLTES
	Examiner		Sequentially list conditions	b			
f,	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	:		
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of			
8760,	cate be ex physician s the buria	aiE		Due to (or as a consequence or	,		
687		edicai		d			
Box (death certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
	that the death sed by the atter detached for L	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.0	at the by th stache	hys	9 🗌 Unknown	9∐ Unknown			
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions	contributing to death but not resulting in t	he underlying cause given in Part I.		co use contribute to the cause of death?
ord	requir een s	ted				1 🗆 Yes	20 No 3 Probably 4 □Unknown
Records,	e law has b	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of
a						1 Yes 2	
Vital	Physician: The law this certificate has t ral director, page 2 s	Be c	25. Was case referred to medical examiner?	Hospital:	Othor	th (Check only one)	
of	> .00 0	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury 28b. Tir	ne of 28c. Injury at	ome Residence	
ion	Attending For death. actor: After by the funer	atio	1∕□Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Inju	Work? M 1 ☐ Yes 2 ☐ No		
Division	f or Attendii after death. Diractor: A	ifica	3 Suicide 6 Could not to determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
	tal or A	Cert		Building, etc. (Specify)		Ony or rown, o	(419)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	29a. Certifier (Check only one) Certifying Pi Certifying Pi Certifying Pi Medical Exa	hysician: To the best of my knowledge, miner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	^		(Ceclan (bent	D23076		6/28/05
	17			completed cause of death (Item 23a) (T	Baltinuas	Me 21	211 Richard
	Sta		31. Date filed (Month, Day, Year)	38. Registrar's Signature	1 4		100, 100, 100, 100, 100, 100, 100, 100,
	Registr	rar	JUN 2 9 200	15 Maria D. B	08462		

			1 - For State Registrar	State of M		id / Depa		t of H	ealth a	and M		giene				
			Hegistrar Decedent's Name (First, Middle,	l ast)			uncan	OIL	Jean		2. Date of Dea	th	200	C	-Time M	55.5
	Physici	an									Month	Day		ear O F	3. Time of	- M
	/Medic		Stanley Leland 4a. Facility Name (If not institution,		.1		4h Cih	Town or	Location of	of Dooth	June	25	County of	05	11:01	_ A
	Examin	er		3	,				Location	JI Death						
	Funeral		Laurel Regional 5. Social Security Number		ge (In yrs.	last birthday)	If Under	rel 1 Year	If Under	24 Hrs.	8. Date of Birth				orge's	
	Funeral Director		236-48-9868	1 X M 2□ F	74		Months	Days	Hours	Min.	8. Date of Birth (Month, Day April 2	, <i>Υθατ)</i> 25 •]	931	Coun	t Vira	ıinia
			Usual Residence of Decedent						1		L L					
	rylan how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	0d. Inside Ci	•
	e Ma	cto	MD Prince	George's		Laur	el								1 🗌 Yes	² ∏No
	th th	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of Wha	I Cour	itry?	
	23a	ai	6604 Carleton C	court				2070	7			USA	<u> </u>			
	r deg	ne	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13. \	Was Deced	lent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	1	4. Race - Black, 1			
36	or It	ΥFι	1 Never Married 2 Marrie	If Yes, Give			1 ☐ Yes		Specify:				Specify:	wh	ite	
21215-0036	illed within 72 hours after death with the Maryland Hygiene. ythar than "natural", or Items 23a or 28a-f show yth, the Medical Examinational be molffled at	Completed by Funeral	3 ☐ Widowed 4 ☒Divorced	Year or Dates		160 Danie	danda Haya	1.000000	-4!			105 105	d of Ducie			
7	"nai	lete	15. Decedent's (Specify only highest	grade completed)		16a. Deced	kind of wor DO NOT us	rk done d	during mos	t of work	ing	160. Kin	d of Busin	iess/ind	dustry	
12	withi ene. than	щ	Elementary/Secondary (0-12) 9th	College (1-4or	5+)	Heavy				arato	or	Co	nstr	110+	ion	
0	Hyg Hyg othar ent,	Ö	17. Father's Name (First, Middle, L.			neary	Bqui	pineri			(First, Middle,			ucc.	1011	
<u>la</u> n	ld be ental ked i	To Be	Stanley Clark						Ve	erna	May For	ma				
Maryland	shound M	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address	(Street a			al Route Numbe		Town, Sta	ite, Zip	Code)	
	nd 2 alth a 27 is		Cindy Fritsch/D	aughter		6604	Carl	eton	Cour	ct,]	Laurel,	MD	2070	7		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-1 show any njury or othar traumatic avent, the Medical Examinet matter notified at ODGs.		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of			Date		ation - Cit	y or To	wn, State	
Ë	Page lenf c nt: If ry or		XX Burial 2 ☐ Cremation : 14 ☐ Donation 5 ☐ Other (Spe			t. Viev		irror pilao		5/29,	/2005	Marr	iott	svi	lle, M	D
alti	pertm Pertm Ports / nju		21. Signature of Funeral Service	cersee						-	naldson			Home	e, P.A	
m	Depermition of the services on the services on the services of		Bannek	enedie	M0016	0 3	13 Ta	lbot	t Ave	enue	Laurel	, MD	20	707		
ſ			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	d the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory arr	rest,			Approximate Interval Bet	
Ш	Physician		Immediate Cause (Final disease or condition			ial In:	forat	dan							Onset and [Death
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Ö,	death certificate be executed e attending physician and sd for use as the burial-transif	Ë	resulting in death) Last	Due to (or a	s a conseq	uence of):										
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9	leath certific attending pl	Physician/Med	IF FEMALE:	00.5 16												
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o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of d	leath 5∟	Other (sp	өспу)							,	
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S	after after Dira	Certification:	4 Homicide		tc. (Specif		,				City or Tow	n, State)				
	spita nours narel		29a. Certifier 1∑ Certifying	Physician: To the bes	t of my kno	wiedge, death	n occurred	at the tim	ne, date an	d place,	and due to the c	ause(s) a	ind manne	er as st	ated.	
	To the Hospital or Attending within 24 hours after death. To the Funarel Director: After completely filled in by the funer	Medical	(Check only 2 ☐ Medicel E one)	xeminer: On the basis and manners	of examina	ition and/or in	vestigation,	in my or	oinion, dea	th occur	ed at the time, o	late and _I	olace, and	due to	the cause(s)	1
	withir To th comp	3	29b. Signature and title of certifier	- 12			29c	. License	number		2	29d. Date	signed (A	Aonth, i	Day, Year)	
_	10		Janle 1/1;	A	/		D	4323	7			Jun	e 27,	20	0.5	
	1		30. Name and address of person w	ho completed cause of	death (Iten	n 23a) (Type,						2 011				
1	<u> </u>		Paul Armstrong				Park I	Driv	e, #1	02,	Laurel,	MD	2070	7		
	Sta		31. Date filed (Month, Day, Year) JUN 29	2005 32 legis	trar's Signa	ature 1	الظماء									
	Registr	ar	0 01100	2002	100	4 Ag										

Physici		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea		3. Time of De
/Medic		Sara Cottrell					Jume 17	7, ^D 2 9005 Y	ear 10:22 a
Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Dea	ith	4c. County of [Death
		2503 Violet Aver				re City			
uneral irector		515-68-2697	7. Age 1 M 2 F	(In yrs. last birthday, Yrs.	Months Days			v, Year)	Birthplace (State or Fo Country) ennsylvania
A =		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City L
f sho	ō	MD		Bal	timore				1 <u>X</u> Yes 2[
r 28a-f show	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?
23a or	at D	2503 Violet Av	enue #1106		21	1215		USA	
ltema Der mi	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	. Was Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No-		American Indian, White, etc.
ral', or it	by	1 X Never Married 2 Marrie 3 Widowed 4 Divorced			1 ☐ Yes 2 No		nto riioan, oto.,	Specify:	white
item 27 is marked other than "natural", or Itema 23a or other traumatic event, the Medical Examinat must be	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+	(Give	edent's Usual Occu e kind of work done DO NOT use retire	a during most of w	orking	16b. Kind of Busin	ess/Industry
other than 'vent, the Me	Con	unk	unk	<u></u>	disabl	ed		non	ne
ed oth	Be	17. Father's Name (First, Middle, La	ast)		unk	18. Mother's N	ame (First, Middle,	Maiden Sumame)	
ls marked o	To	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mail	ling Address (Stree	at and Number or F	Rural Route Numbe	r, City or Town, Sta	te, Zip Code)
ortant: If injury or in		Mary Tulley/ca 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 ☒ Other (Special Service)	B□Removal from State scify) in state	//	ematory or other pla		Date	20c. Location - City	
any ir		21. Signate of Funeral Services I	. Wade, bire		tate Ana Saltimore			Baltimor	e Street
sician	-	shock or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each line	he death. Do not en sive Athe			ovascular		Approximate Interval Betwee Onset and Dea
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JET 05-04165 Iona Darby

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item#18 perFH, G844, 6/29/05 TT

State of Maryland / Department of Health and Mental Hygiene 1- State unpend item#23a,27,28a-f,perMFC244,6/29/05 TT Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Iona Panchita Darby 18 2005 /Medical June 6:00 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 5032 Palmer Avenue Baltimore N/AIf Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Months 1 ☐ M 2 🖫 F 214-84-8136 Yrs. Director 44 1960 Maryland Sept. Usual Residence of Decedent Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, it is Madical Examiner must be notified at Maryland N/A Baltimore tyE Yes 2 ☐ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5032 Palmer Avenue items 23a 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 😭 ☐ No Specify: þ Speci Black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Private Industry 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Arthur Darby Marsha Ennig 2 Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Tiffany Payne/ Daughter 1632 Walters Wood Road Baltimore, Md 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 7/2/05 Baltimore, Maryland Zion Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, Md 21215 Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immate Cause (Final **Physician** Narcotic Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa Disease or a jury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nding physician and use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 Cher (specify) 4

□ Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy enformed? death2 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA To Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1XYes 2 No After thi 27. Manner of Death Page Date of Injury Page Time of Prid njury 28d. Describe how injury occurred unk Certification: 1 Natural 5 Pending investigation 6/18/05 5:50 P M 1 Yes 2 within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5032 Palmer Ave 4 | Homicide Found at home Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME

State Registrar villante

MARUSPUTA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

2005

SORGU. 32 Registrar's Signature

111 Penn Street

19

Baltimore, Maryland 21201

June

2005

Edward Davis 05-04048 crn

			For	State of Ma	aryland /	Depa	rtment of H	lealth and	Mental Hy	ygien	ie	
			1 - State Registrar			Cer	tificate of	Death		Reg. N	00.000	21260
	Physici	an	Decedent's Name (First, Middle, Edward	Last)	Davis				2. Date of D Month	D	ay Year	Time of Digith
	/Medic	al			Davis				June		13 2005	5:03 P M
	Examin	er	4a. Facility Name (If not institution, Prince George's		ntor			r Location of Dea	th		lc. County of Death	
	Funeral				e (in yrs. last b	oirthday)	Cheve If Under 1 Year	If Under 24 Hrs		irth	Prince Geo	
	Director		215-05-4714	1 M 2 □ F	21	Yrs.	Months Days	Hours Min	June 1	ау, Үва		lace (State or Foreign try) .ngton, DC
	pu s		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	um as l as						
	faryla sho	5	MD Prince	Coorge	Capito						1	0d. Inside City Limits 1 X Yes 2 □ No
	the A	Director	10e. Street and Number	George	Capito		10f. Zip Code			10= 6	Citizen of What Coun	
	3e or	Ö	4818 Deanwood Dr				,					try ?
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	20743 Vas Decedent of H	lispanic Origin? (5	Specify Yes or N		S.A. 14. Race - Americ	an Indian,
21215-0036	d within 72 hours atter death with the Maryland jiene r than "natural", or Items 23e or 28e-f show Its Mcdreal Examiner must be notified at	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:	No		Yes, specify Cuba	an, Mexican, Puer Specify:	to Rican, etc.)		Specify: Blac	
5-0	72 h	etec	15. Decedent's (Specify only highest	Education grade completed)	16	(Give I	ent's Usual Occup	during most of wa	rkina	16b.	Kind of Business/Inc	dustry
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	<i>NOT</i> use retired Lvery Mar	1)	·····g	P	rivate	
2	Hyg The	e Co	10th 17. Father's Name (First, Middle, La	st)			Trois indi		me (First, Middle	a Maide	an Sumama)	
an	Q 22 D	B	Edward Herring	,				Chery1		o, marce	in Surname)	
Maryland	and Meni s markers marker	1	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	g Address (Street			ber, City	or Town, State, Zip	Code)
	D & D & E		Cheryl Davis/Mot	her							, MD 20743	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3	Demoval from State	20b. Place	of Dispos	sition (Name of atory or other place		Date		Location - City or To	
Ë	Pag ment ant: I		`4 ☐ Donation 5 ☐ Other (Spe		Harmo		Cemetery	6/21	1/2005	Lar	ndover, MI)
Sall	Depart Import any In		21. Signature of Funeral Service Li	censee	1						ıneral Hon	ne
	40200		22a Bart Enter the disease of a	mal	Laborator Do		74 Lando				20785	
			23a. Part1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final	ity one cause on each lin	ne.					arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. 194	LTIPLE a consequence	que	ushot	Wound	5			
	Examiner			Due to (or as	a consequence	ə (91):						
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	9 01):						
	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
30,	oe exe		resulting in death) Last	Due to (or as	a consequence	e of):						
68760,	cate t physic the b	edicai		d								
Box	ath certif attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)				23d. Date of deliver Month	ry Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown							j		
	res tha signed I be de	by	Part II. Other significant condition	s contributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.			use contribute to the	
0	w requires t been signe should be	eted							10	Yes 2	SAKINO 3 PLODE	ably 4 Unknown
3ec	has has	ompl							24a. Was		24b. Were autop prior to con death?	sy findings available apletion of cause of
Vital Records,	iiclan: The I certiticate ha rector, page	e Co	25. Was case referred to medical						1 Yes	2 🗆 N		2 □ No
	Physiclan: r this certitional director,	o Be	examiner? Yas 2 No	Hospital: 1 ☐ Inpatie		Vistantinat	3□ DOA Oth		ath (Check only		- May 12	
of	F 무 F	n: T	27. Manner of Death	28a. Date of Injur	ry 28b.	Time of	28c. Injun Work		28d. Describe		6 Other (Specify)
Division	Attanding or death. actor: Atter by the funer	Certification;	1 □Natural 5 □ Pending 2 □ Accident investigat	ion 6/13/05	- Fou	Injury 4:		k? Yes 2. <mark>X</mark> XNo	Sub,	PCT	+ shot	
<u>×</u>	l or Attan atter deat Diractor: In by the	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	be 290 Place of lair	ury - At home, t		et, factory, office		28f. Location	(Street a	and Number or Rural	Route Number
Ö	itel or / irs atter ral Dira led in b			bolloning, cit	Fouce	1 0	a stree	+	NE Wa.	shing	to-100	The place
	To the Hospitel or Attanding within 24 hours atter death. To the Funeral Diractor: Atter completely filled in by the fune	edical	29a. Certifier (Check only one) 1 ☐ Certifying 2 ☑ Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination a	ge, death ind/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occu	e, and due to the urred at the time.	cause(date ar	s) and manner as stand place, and due to	ated. the cause(s)
	To the within 2 To the complet	ž	2 Signature and title of certifier				29c. License	a number		29d. D	ate signed (Month, L	Day, Year)
/	215	/	· Caln'i	Mas A	K-		OCM	E		Jun	e 14, 200	5
	5		30. Name and address of person with TABIUU	o completed cause of d	eath (Item 23a)) (Type, P	111 Pen	n Street	Balti	nore	, Marylan	d 21201
	Sta		31. Date filed (Month, Day, Year)		ar's Signature							
DHI	Registr MH 17 Rev 1/20	1	JU	N 2 9 2005	Store	1	ford					
		10.7			200	GINA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per doc 9845 7-6-05 vt
State of Maryland / Department of Health and Mental Hygiene

Amend Item 1 per doc 845 7-12-0 vt

Amend Item 1 per doc 845 7-6-05 vt

Amend Reg. No. 2 0 0 m 1 - For State Registrar Sharits 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Lola Sharitis Davison Lola Sharita Davison JUNE 26,2005 12:10P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER CHARLES LAPLATA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 07,1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 579 14 5377 1 ☐ M 2 🖫 F 93 Yrs. Director Ohio Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 27 is marked other than "natural", or Itema 23a or 28a-f shov traumatic event, the Madical Examiliar most be motified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland Prince George Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8109 Bock Road 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MMo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within College (1-4or 5+) Elementary/Secondary (0-12) 2 should be filed with and Mental Hygiene. Manager 4 Food Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellsworth Harvey Nora Lemons 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 la any injury or other traconce. Carolyn Saucier (Daughter) 1002 Sherman Court, Waldorf, MD 20602 20a. Method of Disposition

* ∠ABurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 30, 2005 20c. Location - City or Town, State Suitland, Maryland Cedar Hill Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Savice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d Alexandira Ferry Rd, Clinton, MD 20735 M00257 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one partie on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENVERSAA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, Examiner ig physician and as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 detached the 9☐ Unknown 9 Unknow à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ icate has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 X X XX No 1 Tyes 1 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signaty and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-20629 3 address pers who completed cause of death (Item 23a) (Type, Frint) GEORGE H. WATHEN MD 11345 PEMBROOKE SQ. SUITE103 WALDORF, MD 20603 31. Date filed (Month, Day, Year) State Registrar Glave L. Specker

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Nouglas 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death altimire urulana If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In y s. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 18 Days Months Hours 1 M 2 XF 6844 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 Yes 2 No BALLIMURE MID 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1349 N. Rolling 21278 4.5-A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry WXXIC

Approximate Interval Between Onset and Death

Day

2 🗆 No

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23s. or 28e-f show any highry or other traumatic event, the Medical Examinatings be notified at once.

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Physician

/Medical

Examiner

by Funeral Director

Completed

Be

Funeral

Director

Physician /Medical **Examiner**

The law requires that the death certificate be executed

attending physician and for use as the burial-transit detached by Completed Be filled in by within 24 hours a To the Funerel L

certificate has

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After t

Director:

or Attending

Hospitel

To the

Physician/Medical Certification: To Medical

College (1-4or 5+) Elementary/Secondary (0-12) Comestic WERK Dum Estic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barle TRANK (1dg/man 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a-Informant's Name/Relationship ype, Print) N. Lalling Led Doug las BA HIMORE MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) GREENMUNT CEMETERY 6/23/05 21. Signature of Funeral Service Licensee 22. Name and Address Facility BEHS Functil Home Corpoline of BAILIMURE NO 21213 Johnson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pheumonia disease or condition resulting in death) consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due for as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 □ Yes 2 □ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 PNo 1 🗌 Yes 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

23a) (Type, Print)

address of person who completed cause of death (Item

Date filed (Month, Day, Year)

JUN 2 9 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** P^{M} Eades June 26 2005 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing Home Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔼 F Months Days Hours 97 Director 220-74-7711 6 1908 South Carolina Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits in then "neturel", or Items 23e or 28a-f show the Medical Evanities must be redified at 1X Yes 2 □ No Director College Park Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 9125 Bridgewater Street U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after ☐Yes 2XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Completed by Specify. 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "simportent of the then "some injury or other treumatic event, the Head once." Elementary/Secondary (0-12) College (1-4or 5+) 3rd Home Maker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maria George Eades Tennant 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9125 Bridgewater Street College Pk. Maryland 20740 Sallie E Welch /Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 7/2/05 Brentwood, Maryland 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 Part1. Enter the Jise 1.5. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final H581847164 PREUMUNIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner FIBRICE POLON The law requires that the death certificate be executed use as the burial-transit ATRI AL the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai てけらならうとしたにし まい」 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DENAL ULCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dnknown Completed been ANEMID 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ALUTEMIA performed? certificate 1 Yes 2 No 1 Yes 2√2 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 T Homicide To the Hospitel within 24 hours a To the Funerel C completely filled i Hospitel Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19971 06 27 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudhakar M.D. 7610 Carroll Avenue # 230 Takoma Park, Maryland 20912 Kempanna 31. Date filed (Month, Day, Year) State JUN 2 9 2005 Bloom St. Boute Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2005 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ρ. Fisch Virginia /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Dea Examiner ARINEI If Under 24 Hrs. 8. Date of Birth (Month, Day, APR 9, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) ial Security Number 6. Sex Funeral Days Min. 1 □ M 2 X F Months Hours 1915 Delaware Director 125-01-3657 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "naturat', or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Erain artificial by cottle of all once. 1 ☐ Yes 21 No Director Bel Air MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21014 300 W. Ring Factory Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [M] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 ₩Widowed 4 Divorced white 16a. Decedent's Usua! Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Clerk 12 Pharmaceutical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Palmatary Walraven Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1104 Runnymede Lane, Bel Air, MD Rebecca Glenn, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. | 6/29/2005 Beltsville, MD ²² Name and Address of Facility CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21. Signature of Funeral Service Licensee M00986 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. eet and Death Immediate Cause (Final NEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jusease on injury that initiated events Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Certification; To Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CANC 2 PNo 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a Wasan page 2 s 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 27. Manne f Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident after death the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 \ Homicide Vithin 24 hours are.
To the Funaral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Robert

Registrar

State

31. Date filed (Month, Day, Year)

SNOWND

Au MD 21014

ne and address of person who completed cause of death (Item 29a) (Type, Print)

2005

2. Registrar's Sanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. NO 0 5 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2005 3:00 A M Mary E. Fowler June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riverview Nursing Rehab Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min. 70 Director 215-30-7080 3/23/1935 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ahow 10a, State 10b. County the Medical Examiner must be notified at MD Middle River Baltimore 1 ☐ Yes X☐ No Be Completed by Funeral Director or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3209 Foxalove Avenue or Itams 23g 21220 U.S.A. death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bakery 8th Retail Sales other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Bilz 10 Mary Holtzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and a sout of Health a nt: If item 27 is a Barbara Todd / daughter 112 Spry Island Rd. Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Gardens of Faith 6/29/05 Rosedale, MD ure of Funeral Service Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician -una /Medical Due to (or as a consequence of): **Examiner** VIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (as a consequence of) Examine Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Ohe VEN'L Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? Division of Vital Records, 1 XY es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy certificate 2 No 1 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 XNo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 No death. 1 Tyes 2 Accident Director: / 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide filled in ha Funeral D Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 itle of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 2 27/205 6055171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Box 68760.

P.O.

302

Signature

70PM 32. Registra

JUN 2 9 2005

CISTERN

HUE .

21224

Kevin Fridley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#8, per FH, G849, II = 3-05 TT Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05-04224 N.JM 1- State Unpend Item 230&27 per me G845 7728 and of Beath Rag. No? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death! Month Day **Physician** Kevin June 2005 0910 /Medical 4a. Facility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death **Examiner** 688 West Shore Road Pasadena Anne Arunde1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 972 Birthplace (State or Foreign Country) **Funeral** Months Days Min 102M 2□F Hours O18-56-3198 Usual Residence of Decedent Director larch death with the Maryland 10a. State 10h. County 10c. City, Town or Location Show 10d. Inside City Limits ?? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director tnne 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 688 Ro allad 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Year or Dates: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ealth 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h edric 0 20h 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod if Item 27 is 20b. Place of Disposition (Name of camelery, cramatory or other place)

20c. Locatin - Cit. onstanc mother other 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State ö permit. Page Department of Important: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) etro xematory 21. Signature of tinery Service Licenses 22. Name and Address of Facility valla EEGI MA 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Probable Cardiac Arrythmia Due To Atrial Fibrillation function in death)

a. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but the disease or condition are caused in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but the death de Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ funeral director, page 2 should be 3 Probably 4 ⊈Unknown Be Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene Certification: To 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME

State Registrar

31. Date filed (Month, Day, Year)

JUN 2 9 2005

E

arrack

Humela

Southall, MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OUTHALL MD

82. Registrar's Signature

111 Penn Street

June, 22, 2005

Baltimore, Maryland 21201

05-04298 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dorlethina Fayall State of Maryland / Department of Health and Mental Hygiene
Unpend Item 23a,27,28a-f per me G846 8-18-05 tas
Reg. NO
Reg. NO **RJD** 2. Date of Death 1. Decedent's Name (First, Middle, Last) orlethina June 25, 2005 all **Physician** 0804A. /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 219-76-0289 Yrs. Director nary Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 Pres 2 □ No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? ö filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White-eto: 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 12 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sabled 7 is marked othe traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any jury or other traumatic event once. Be Horae tayal Keeves ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relations ip (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Baeto. md, 21216 Windson miller 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State -1-05 4 Don. tion 5 Other (Specify) mead on lidge 22. Name and Address of Facility re of Funeral Service Lice Franklin Rineral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart allure. List only one cause on each line. Boeto, ma Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Physician Seizure Disorder due to Head Injuries(remote) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death 2□ No certificate Yes Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 2 ER/Outpatient 3 □ DOA 2 Y Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of unk 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: unk After 1 Natural 5 Pending Approx.1979 2 No death. 1 TYes Blunt force trauma investigation 2 Accident within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number.unk City or Town, State) unk 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medicai

31. Date filed (Month, Day, Year) JUN 2 9 2005

Myme

(Check only one)

29b. Signature and title of certifier

MARYSMOS

KOREU 32. Registrar's Signature

sell

W

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number OCME

30. Name and address of person who completed cause of death (Item 23a) (Type, Pim) Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

June 25, 2005

			1 For State	State of Ma	arylan		artment of h		d Mental Hy				
			Registrar 1. Decedent's Name (First, Middle, Las	(r)		Cel	uncate or	Dealli	2. Date of De	Reg. No.)5	2 1 3	75
	Physicia		Barbara Butche	_					June	Day	Year 2005	1:25	a M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of D		4c. County		1.43	а
			Gilchrist Center	or Hospic	e Ca	re	Towson			Balti	more		
	Funeral Director		5. Social Security Number 6. Social Security Number 1	9x 7. Age □ M 2X F	e (In yrs. 6.	la <i>st birthday)</i> 3 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bin Min. (Month, Da May 29	1942	9. Birthpl Coun Oh	ace (State of	or Foreign
	pu 🕽 =		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation				11	Od. Inside C	its Limita
	death with the Maryland ms 23a or 28a-f show froust by multired at	ō	MD Howard	3		umbia	oation				'		2∏No
	the N	rect	10e. Street and Number	1	COL	dinora	10f. Zip Code			10g. Citizen of \	What Coun	try?	
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	ems 2	Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.		Was Decedent of I	Hispanic Origin'	? (Specify Yes or No	- 14. Rac	e - America		
0	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 1 N	No		1 □ Yes 2 XNo			Specify			
200-	hours tural'		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		16a Decec	dent's Usual Occur	nation		16b. Kind of Br	whi		· · · · · · · · · · · · · · · · · · ·
<u>.</u>	nin 72 n *na	plet	(Specify only highest gra	de completed)		(Give	kind of work done DO NOT use retire	during most of d)	working	100. Killa of Bi	23111033/1110	ustry	
7	d with giene ar tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5	·+ <i>)</i>	Teach	er			Public	Educa	ation	
<u>a</u> 110	at Hy d othe	Be	17. Father's Name (First, Middle, Last)						Name (First, Middle,		тө)		
<u>y</u>	ould I Men Parke Patic	ပ္	Wendell Allen	Butcher				Eleno		Noll			
Mal	d 2 sk th and 7 Is n traun		19a. Informant's Name/Relationship (19a Martin Gear - hus				•		r Rural Route Numbe Columbia,			Code)	
5	Heall tem 2 othar		20a. Method of Disposition	Joana	20b. P	lace of Dispo	sition (Name of		Date	20c. Location -		wn, State	
ē E	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify				natory or other pla Crematory		27/2005	Beltsvi	11e.	MD	
апптог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or othar traumatic event, If s Modeal Examiliant is ust be multiled at once.		21. Signature of Funeral Service Licen	_	MOO	006 22							
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	dications that caused one cause on each lin	the deati	n. Do not ente	er the mode of dyi	ng, such as car	diac or respiratory a	rrest,		Approximat Interval Bet Onset and	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pancr	cati	c Ca	ncer					nont	
	/Medical Examiner		1950ming in deathy	Due to (or as	a conseq	uence of):							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a conseq	uence of):							
	cuted od ransit	Examine	that initiated events	C									
Š	e exercian ar urial-t	EX	resulting in death) Last	Due to (or as	a conseq	uence of):							
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o X	certific ding p	0	IF FEMALE:	23c. If yes, outcome	of pregna	incv				23d Dat	te of delive	0/	
מסא	death atter	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1⊡Live birth 4⊡Pregnant at	2 Feta	Ideath 3□	Ectopic pregnanc Other (specify) _	у		Mo		,	Year
Ċ.	t the c by the tached	hysi	9 🗆 Unknown	9□ Unknown									
Š,	The law requires that the death certifi ate has been signed by the attending t page 2 should be detached for use as	by P	Part II. Other significant conditions of	-		-				obacco use cont			
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	ding Physician: The lav n. After this certificate has funeral director, page 2:	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospitał: 1 ☐ Inpatie	nt 2 🗆	ER/O <i>u</i> tpatien	t 3 DOA Ct		Death (Check only only only only only only only only		er (Snacity	Hospi	-
0	g Phy er this eral d	 	27. Manner of Death	28a. Date of Injur (Month, Day	ry	28b. Time of				how injury occuri		, clook	
UIVISION	anding ath. or: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y rear	Injury		Yes 2 □No					
<u> </u>	or Atter ter de irecto	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At ho c. (Specif	ome, farm, str	eet, factory, office		28f. Location (: City or Tox	Street and Numb vn, State)	er or Rural	Route Num	iber,
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	24 hos	edical		ysician: To the best on niner: On the basis of and manner sta	examina								;)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Mec	29b. Signature and title of certifier	21			29c. Licen:			29d. Date signe			
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t	DVI		30. Name and address of person who	completed cause of d	eath (Iten	1 23a) (Type,	Print)	C -1	1 _ 2	1615	- 1	2 . ^	
_\	, U		30. Name and address of person who Jason (Slack) 31. Date filed (Month, Day, Y97)	6565 N	0514	Char	lesst	suite,	103 1091	Imore, W	14)	2120	7 -1
	Sta Registr		31. Date filed (Month, Day, You)	3 9 2005 Begistra	Signa	w K	Goode						

			1 - State Registrar		epartment of Health a	, ,	ene • @ D D E '	ררפוכ
	Physici	an	1. Decedent's Name (First, Middle, Last)	. C.		2. Date of Death Month	27 2005	3. Time of Death
	/Medic Examir		Joseph Francis Golla 4a. Facility Name (If not institution, give street an NOVHN Arwale)		4b. City, Town, or Location of Glen Burn	June of Death	4c. County of Death Anne Avu	udel
	Funeral Director		5. Social Security Number 6. Sex 215-28-1031 6. Sex	7. Age (In yrs. last birth	nday) If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birth (Month, Day, 4–3–1931	Year) 9. Birthpla Count Mary I	ace (State or Foreign ry) and
	death with the Marylend ms 23s or 28e-1 show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland n/a 10e. Street and Number	10c. City, Town Ba1	or Location timore	100	g. Citizen of What Count	od. Inside City Limits 1 X Yes 2 □ No
5	23a or		600 Light Street U	nite 928	212		nited State	
deep		by Funeral	1 Never Married 2 Married 1 1	Decedent Ever in U.S. ad Forces? fes 2 No s, Give or Dates:	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1 Yes 2 No Specify:	gin? (Specify Yes or No- i, Puerto Rican, etc.)	14. Race - America Black, White, e Specify: Wh	
7	IZ IS-UUSO within 72 hours after ene. then "natural", or its he Medical Exemine	Completed		ge (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most life. DO NOT use retired)	t of working	6b. Kind of Business/Indi	•
1 00	nd Z se filed al Hygi tother went.	To Be Co	12 years 17. Father's Name (First, Middle, Last) Michael Frank Gollar,			or's Name (First, Middle, Magaret Simmons	aiden Sumame)	G.
	C = 44 F		19a. Informant's Name/Relationship (Type, Print Patricia Reed (daugth 20a. Method of Disposition	er) 806	Mailing Address (Street and Number 3 Catherine Ave.	Pasadena, M		
	ILIMO		1 XBurial 2 ☐ Cremation 3 ☐ Removal 1		Disposition (Name of crematory or other place) ross Cemetery 7	′-1-2005 B	rooklyn Par	
Ġ	Department of the control of the con		21. Signature of Funeral Service Licensee		22. Nome and Address of Facility McCully-Polynia McCully-Polynia 130 E. Fort Ave	k Eneral Ho Baltimore,	me PA MD 21230	
•	Physician /Medical		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	d Stage P	nt enter the mode of dying, such as		st,	Approximate Interval Between Onset and Death
031	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a to (or as a consequence of to (or as a consequence of e to (or as a consequence of	Arteny Dis	el se		
ď	death certific e attending p	Physician/Med	in the past 12 months?	s, outcome of pregnancy ive birth 2 □ Fetal death regnant at time of death Inknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliven	y Day Year
0	w requires that it been signed by should be deta	by	Part II. Other significant conditions contributing	to death but not resulting in t	he undertying cause given in Part I.		cco use contribute to the	. /
	The law recalled the rest of t	Completed				24a. Was an autopsy performe	prior to comi	sy findings available pletion of cause of
7:57	yelcien: The secrificate director, pag	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Hospital:	1 Inpatient 2 ER/Outp	Other	of Death (Check only one)		
2	Attending Physicien: r death. sctor: After this certific by the funeral director,	ation: To	27. Mano r of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury Month, Day Year) 28b. Tir	ne of 28c. Injury at	rsing Home 5 Residence. 28d. Describe how		
	To the Hospital or Attendin within 24 hours after death. To the Funetel Director: All completely filled in by the full.	Certification:		Place of Injury - At home, farmuilding, etc. (Specily)		City or Town, S	,	
	ne Hosp n 24 ho ne Fune	Medical	(Check only 2 Medical Exeminer: On t	o the best of my knowledge, on the basis of examination and/ manner stated.	death occurred at the time, date and or investigation, in my opinion, deat	d place, and due to the cause the occurred at the time, date	se(s) and manner as stat e and place, and due to the	ed. he cause(s)
•	To the within To the To the Comp	N	26b. Signature and title of certifier Leone C. U	July 199	M.D. 29c. License number D4136	S 29d	1. Date signed (Month, Da	2005
19	100		30. Name and address of person who completed George E. Wills	cause of death (Nem 23a) (T	M.D. D4136	rive, Glen	Burnie, M	D, 21061
	Sta Registr	- 4		2. Registrar's Signature	South)			

to Moonital or Attanding Dhunloise. The land show the shoot has the death as all the standard of the standard

			Please 1	Гуре or Print in Black I			
			For State	State of Maryland / De			
			Registrar 1. Decedent's Name (First, Middle, Last		ertificate of Death	Reg.	2005 21378
	 Physici /Media 		Mariorie +	1. Greene			Day Year 24 2005 829 PM
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of De-	ath	4c. County of Death
			5. Social Security Number 6. Se	Galtimar e 7. Age (In yrs. last birthda	Paltinum Cit	J	VIA
	Funeral Director			M 2 F 112 Yrs.	Months Days Hours Mi		9. Birthplace (State or Foreign
	72 hours after death with the Maryland natural", or Items 23c or 28a-1 show Acal Examinal mast be motified at	ctor	10a. State 10b. County Mb Baltim	10c. City, Town or Randal	Location (Istown		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with th	by Funeral Director		Hill Circle Apt.G		U	Citizen of What Country?
	ter de Items inter-	nne	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- into Rican, etc.)	14. Race - American Indian, Black, White, etc.
215-0036	72 hours after dea "natural", or Items	ed by	3 Widowed 4 Divorced	If Yes, Givé Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
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Maryland	Mental Mental arkad o	To Be C	17. Father's Name (First, Middle, Last) Leo Greene			ame (First, Middle, Maid	len Sumame)
Mar	d 2 sho th and 7 is my traum		19a, Informant's Name/Relationship (Ty	pe, Print) 19b. Ma	iling Address (Street and Number or F	Rural Route Number, Cit	y or Town, State, Zip Code)
	ss 1 and 2 of Health itam 27 i		20a. Method of Disposition	20b. Place of Dis	oosition (Name of	Date 200	Location - City or Town, State
OM.	Pages nent of I int: If its		1 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	lemoval from State Mt. Zion	ematory or other place)		nsdowne, mo
Baltimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Licens		22. Name and Address of Facility		ne P.A.
<u></u>	205 20		Get 1	hand	70 Fredhilfonfas	S BALTO M	10 21224
	Physician /Medical		23a. Part1. Enter the disease, or complishock/or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	TO CAUSO OF BACH INTO.	whage E herniation		Approximate Interval Between Onset and Death 2 days
L	Examiner		Sequentially list conditions,).			
	ed sit	aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
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68760,	ficate be exe physician a s the burial-1		L .	l			
68 ×	artifica ing ph a as th	Med	IF FEMALE:				
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Vunknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	es that igned b	by Pi	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Records,	w require been sig should b	ted t	HIV	circhosis		1 ☐ Yes	2 No 3 Probably 4 Unknown
ecc	e law r has be ge 2 sh	Completed	seizure dlo			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al B	ilcian: The certificate ha rector, page		нти			performed? 1 ☐ Yes 2 🐼 N	death?
Vital	yslcian is certii directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☑Inpatient 2 ☐ ER/Outpatie	Othor	ath (Check only one)	
J Of	ding Phy h. After this funeral c	- 1	27. Manger of Death	28a. Date of Injury 28b. Time	xit 3 DOA 4 Nursing I	fome 5 Residence 28d. Describe how in	
Sior	Nttandir death. ctor: Af y the fur	catic	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) Injury	M 1 Yes 2 No		
Division	l or Att after d Diract I in by I	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
_	spital		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the caucal	(a) and manage as stated
	To the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examinone)	er: On the basis of examination and/or i and manner stated.	vestigation, in my opinion, death occ	urred at the time, date a	nd place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License number	29d. D	Pate signed (Month, Day, Year)
	ŋ		Harper a	M.D.	1662 -000	ブ	INE 24,2005
	~		30. Name and address of person who con Tolephi CHEN M.	_	Print) RE AVE BALTIMORIE	אם אימיב	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar Bignatu	D JACK ONL	, MD ZIZIE	>
	Registr	ar	JUN 2 9 2005	Mary 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** June_21 2005 Frances Ann Hayes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🛱 F Yrs Director 1942 217-38-5079 July 23, Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County iral', or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Directo MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1901 August Avenue 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: white þ 3 Widowed 4 Divorced "natural" Completed 77 Is marked other then "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Charles Conley Hayes Bessie Margurite Ervine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 1901 August Avenue Baltimore, MD Charlotte M. Hayes/sister itam 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If ita
any lajury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Fonald 8. Wad 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street rector Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final esuphason Physician month, disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day ŏ Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has b 24a. Was an certificate ! 2 **36**00 1 ☐ Yes tha Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Wher (Specify) 1 ☐ Yes 2 🗹 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA ihis 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) ignature and title of certifier 58303 JUNE 21 2005-

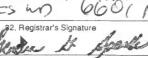
State Registrar

31. Date filed (Month, Day, Year)
JUN 2 9 2005

Amon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES WO



Baltimore, Maryland 21215-0036

Box 68760.

Records,

Division of Vital

200

Charles St DWW ND 2/204

CPM05-04304 Charles Harris

Baltimore, Maryland 21215-0036

Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2005 16:15 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University Hospital-Shock Trauma Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs, last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1**™** M 2□ F ノス Yrs. 213-72-6007 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or items 23s or 28s-f showing the continued at 1 Nes 2 No MP Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Av enuz 1862 21201 armine 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 🖰 No 6 Specify: Specify: ir then "naturel", o þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 Is markad other then 'r treumatic event, Ir e Ma Elementary/Secondary (0-12) College (1-4or 5+) ourier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be harles 1111ams 19b. Mailing Address (Street and Number or wral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carmine permit. Pages 1 and 2 Department of Health a Importent: If item 27 ls any injury or othar tret once. PHITO. Spo use Monica 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 21. Signature of Funeral Service Licensee 1JOI MEMICH 2 22. Name and Address of Faility Canton C. Douglass tuneral Service BALTO. Mb 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Blumt Force Head Injuries Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physicien: Tha law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physicien Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the a 9 Unknown 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ After this certificate has been signifuneral director, page 2 should be 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 🖾 Yes 2 🗆 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 ☐ No 5 Residence 6 ☐Other (Specify) Medical Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury assulted 5 Pending investigation subject was 1 Natural 1 ☐ Yes 2 No PM 6-24-05 18:26 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 820 East Plaston 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide At a vacant house street Baltimore mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier hu, OCME 6-26-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 LI MIL 32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

JUN 2

31. Date filed (Month, Day, Year)

2005

ORIGINAL

			For State	State of Maryland / Depa	artment of Health and Martificate of Death			21381
	Physici	ian	Registrar 1. Decedent's Name (First, Middle, Las) [[imeate of Beatin	2. Date of Death Mopth	Day Year	3. Time of Death
>	/Medic	cal	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	6-26	4c. County of Death	8:30 A™
			6612 Eberle D	r. #203	Baltmore If Under 1 Year If Under 24 Hrs.	O. Date of Dish	O Birth	
	Funeral Director		210-20-0111	7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth Wonth, Day, Yes	2 9. Birthol	ace (State or Foreign try)
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			10	0d. Inside City Limits
	the Ma 28a-f s	Director	10e. Street and Number		nore 10f. Zip Code	100.6	Citizen of What Coun	1 Yes 2 No
	ath with		6612 Eberle	Dr. #203	21215		USA	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentat Hygiene. If Items 27 is marked other than "natural, or itams 23e or 28a-f show or other traumatic avant, the Mudical Exam is a multiple notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 27 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	an Indian, etc.
15-0	in 72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	de completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b.	Kind of Business/Ind	lustry
2121	filed within Hygiene. whar than ant, the Mas	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	ses Assistan	t H	ealth (are
land	2 should be filed withir and Mental Hygiene. Is marked othar than raumatic avant, Ite M	To Be	17. Eather's Name (First, Middle, Last	arris	18. Mother's Nam	an Nidelle, Maid	i ams	
e, Maryland	1 and 2 should Health and Men tam 27 is marke		19 Informant's Name/Relationship (7)	Leris Daughter 196. Mailir	ig Address (Street and Number or Run	ral Royte Number, City M. Balto	, MD 21	215
Baltimore ,	Pages 1 nent of H int: If its		20a. Method of Disposition 1	Hemoval from State	natory or other place)	Date 20c.	Balkman	wn, State
Balti	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		21. Symplure of Funeral Service Lio	22	Viame and Address of Facility	ne fune	raf Ser	ALD 21132
	∴		23a. Part1. Ette the disease, or comp shock, of yeart failure. List only	lications that caused the death. Do not enture cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	Lancer		Λ	Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions,	b				
	cuted nd ransit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of).				
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
9	ertificate ling phy e as the	Medicai	IF FEMALE:	0.				
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 mgnths?		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
P.0	that the ed by th detache	Phys	9 ☐ Unknown	entributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ords,	w requires that been signed should be det	ted by				1 ☐ Yes		ably 4 DUnknown
Records,	ne law re has be ge 2 sh	Completed				24a. Was an autopsy performed2	prior to corr	esy findings available appletion of cause of
Vital		Be Co	25. Was case referred to medical examiner?		26. Place of Deal	1 ☐ Yes 2 ☐ 1 th (Check only one)	No 1 ☐ Yes	2 No
of	Phy rthis ral d	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of	28c. Injury at	ome 5 Residence 28d. Describe how in	6 ☐Other (Specify,)
Division	Attending Phor death. ector: After this by the funeral	cation	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
DIVI	al or Attences after death	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, streed building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta		Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) Certifying Phrone)	sician: To the best of my knowledge, death iner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, D	
,	W		30. Name and address of person who	on pleted cause of death (Item 23a) (Type,	037928 Print) Belve Ine Ave Sut		ne 21,2	005
4	7		Robert K July 31. Date filed (Month, Day, Year)	mo 2435 Unis /	Belve Leve Ave-Suit	c22 Bellim	or most	715
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2005 8:30 AM M William Farley Harrison June 11. /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner 1540 Chilworth Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 □ F Director 232-64-0274 64 West Virginia Jan 11,1941 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f shov other traumatic event, the Mudical Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Directo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1540 Chilworth Avenue or Items 23a 21220 by Funeral USA Peges 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. and terms 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 \(\text{No}\) No If Yes, Give Year or Dates: \(\frac{1}{59-64} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 truck driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles William Harrison ٥ Mary Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1540 Chilworth Avenue Baltimore, MD Roselle M. Harrison/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges 1 Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5 ☐ Other (Specify) Ronald S. Wade State Anatomy Board 655 W. Baltimore Street baltimore, MĎ nan 21201 Enter the disease, or complications that eaused the heart failure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Me Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospitel or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical eave cancer IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 Z No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 TYes 2 No death. 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W41614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUB 4920 ww 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Jeane JUN 2 9 2005 Registrar

JET 05-04351 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Garland Albert Johnson Johnson State of Maryland / Department of Health and Mental Hygiene

1- For State Unpend Item 23a,pt.II,27 per me G845 7-20-05 tas

Certificate of Death

Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** ALBERT GARLAND **JOHNSON** 2005 June /Medical 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6610 Woods Parkway Apartment 3 B Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X**1M 2□ F Yrs. Director 50 10-14-1954 MD 213-64-8557 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d Inside City Limits 10a. State rel', or Items 23a or 28a-f show Examinational be notified at 1X Yes 2 □ No ŏ MD BALTIMORE DUNDALK Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6610 WOODS PARKWAY #3B 21222 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2X XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1975-78 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK "neturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MASH'S HAM LABORER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked ott Be JUANITA KING JOHN ALBERT JOHNSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6610 WOODS PARKWAY #3B BALTIMORE, MD 21222 ROSALIND JOHNSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST CEM. 7-1-05 OWINGS MILLS, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 orton 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Hypertensive atherosclerotic cardiovascular disease **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury burial-transil and that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760. The law requires that the death certificate be Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. the th 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 4 Unknown 1 Yes 2 No 3 Probably Liver cirrhosis page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No D) es 2 No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 XYes 2 □ No 3□ DOA this [unera] 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Certification: Injury at Work? After Injury 1 X Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME 2005 28

OP VA

31. Date filed (Month, Day 29ar) State Registrar

gistrar's Signatur

30. Name and address of person who complete cause of dia (Item 23a) (Type, Print)

(HESOONE MIKE

111 Penn Street

June

Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** TORDAN TUNE 2005 AGGIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Agnes Henithcare Buttmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 23/-34-78 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Director 16,11 Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City. Town or Location 10d, Inside City Limits Item 27 is marked other than "neturel", or Items 23s or 28e-f show other treumatic event, the Madical Examiner must be notified at 1. Yes 2 □ No Director 11/12/1/18 10e. Street and Number 10g. Citizen of What Country? 102: STREET USA. Completed by Funeral death v permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel" ~ " any injury or other treumatic excessions." Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THGRADE OWN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) STEVENSON TAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TORDAN (SON. BUR KHARDT. MO. 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 06-29-05 CATONSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) WESTERN STAR BROWNUTR. FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEHYDRATION WEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BREUST CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ♠ No PUCMONAMY EM BULISM 24a. Was an autopsy the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 1 Yes 2 No 1 Propatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide

within 24 hours a To the Funeral L completely filled

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

10061765

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EBENEZEN 33.50 WILLIEMS AUE BALTIMINE 21225 QUAINOO

State Registrar

Medical

29a, Certifier

9b. Signature and title of certifier

32. Registrar's Signature 2005 Horne

				State of Ma	ryland / Depa	artment of H	lealth and M	lental Hyg	iene		
			1 - State Registrar		Ce	rtificate of	Death		9. N2 1 1	2/385	
	Dhysisi		Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Ye	3. Time of Death	
	Physici /Medic		BARBARA	L. JACK:	SON			JUNE	24 200		
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of E	Death	
			HARBOR HOSPI	TAL CENT	ER	BALTIMO	ORE		N/A		
	Funeral		Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	0	Birthplace (State or Foreign Country)	
	Director		216-48-9786	□M 20XF (52 Yrs.	Months Days	Hours Min.	June 3.	1943 N	Maryland	
	ъ		Usual Residence of Decedent								
	ylan how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits	
	Ma Ma	tor	Md. Anne Aru	ndel	Baltim	ore				1 ☐ Yes 27 No	
	h the	ire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	t Country?	
	72 hours after death with the Maryland natural', or items 23e or 28e-f show disal Evacal art must be notified at	Funeral Director	7104 St. Lauren	Ct.		212	226		U.S.A.		
	deat ms ms	Jer	11, Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		American Indian,	
9	after or its	F	1 Never Married 20 Married	Armed Forces? 1 ☐ Yes 2 No	1	1 ☐ Yes 2 No		rican, etc.)	_	Vhite, etc.	
<u> </u>	i within 72 hours affiliene. Jiene. r than "natural", or Tha Medical Evar.	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		TLIYES ZALINO	Ѕреспу:		Specify: W	vnite	
9	2 hc	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	ina	6b. Kind of Busine	ess/Industry	
2	within 7 ene. than "r	pie	(Specify only highest gra-	College (1-4or 5+	life.	DO NOT use retired	during most of work d)	ng			
2	d wil	тo	9	0		se Wife			Own Hon	ne	
Þ	be filed htal Hygie ed other event,	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	faiden Sumame)		
<u>a</u>		To E	Charles Settle	ê			Clet	a Suite			
Maryland 21215-0036	2 should and Men is marker aumatic		19a. Informant's Name/Relationship (7	ype, Print) (Hush	and 19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	City or Town, Stat	te, Zip Code)	
	ges 1 and 2 should t of Health and Mer if item 27 is marke or other traumatic		Henry Patrick Jac				en Ct. Bal				
ē,	F Hez F Hez Item othe		20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City		
10	Pages nent of l int: if it		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Glen Have	n Me m. Pk	6-27-	-05 (Glen Burn	ie, Maryland	
Baltimore,	permit. Pag Department Important: I any injury o	l l'i	21. Signature of Funeral Service Licen		/ 2	2. Name and Addre	ss of Facility	_			
Ba	permit. Pag Department Important: i any injury o	10	Mena m CA	Town of the	6 1	30 F For	McC	Cully/Pol	lyniak Fu	n, Home P.A. d 21230	
			23a. Part1. Enter the disease, or comp	plications that caused t	he death. Do not en	ter the mode of dvin	ic. such as cardiac	or respiratory arre	st.	Approximate	
	30 V		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line				, , , , ,		Interval Between Onset and Death	
	Physician /Medical	8 19	disease or condition resulting in death)		capitatory	Distress S	indrome				
	Examiner			,	consequence of):						
		7	Sequentially list conditions,	b. END 5	146E ZE	-NAL DIS	EASE				
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. DIABETES MELLITUS							
	and I-trar	Examiner	that initiated events resulting in death) Last	c. DIADETE	consequence of):	1145					
760,	be executed sician and burial-transit			d HYPERT	, ,						
87	cate chysi the	dicai		d	ENSTOR					+	
x 68	leath certificat attending phy I for use as th	Me	IF FEMALE:	23c. If yes, outcome of							
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year	
o.	at the de by the a tached f	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	me of death 5L	Other (specify)					
<u>G</u> .	The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	Ph)	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	nderhing egune gw	on in Part I	23a Did tob	acco use contribut	e to the cause of death?	
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50	w require been si should I	ted	PERIPHERAL V.		~~**			10	2 2 110 3	Trobably 4 Dominionin	
ec	has b	Completed	CONGESTIVE H	EART FA	rilure			24a. Was ar autopsy	prior	autopsy findings available to completion of cause of	
<u> </u>	The I	Con						perform		h? Yes 2☐No	
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death				
Ž	hysic lidire	2	1 ☐ Yes 2 ☐ No		2 ☐ ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing Ho	me 5 Reside	nce 6 Other (S	Specify)	
0			27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o		v at	28d. Describe ho			
<u>.</u>	ath. or: Al	atic	2 Accident investigation				Yes 2 □No				
Division	ial or Attendii s after death. al Director: A ed in by the fu	tiflo	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At home, farm, sti (Specify)	reet, factory, office		28f. Location (Str. City or Town,		r Rural Route Number,	
	spital or ours afte neral Dir filled in	Certification:		,			1	,	,		
	e Hospital or Attending 24 hours after death. e Funeral Director: After letely filled in by the fune		29a. Certifier Certifying Ph	ysicien: To the best of niner: On the basis of e	my knowledge, deat	h occurred at the tin	ne, date and place,	and due to the ca	use(s) and manner	r as stated.	
	To the Hosp within 24 ho To the Fune completely f	Medical	one)	and manner state	ed.						
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licens			d. Date signed (M		
•		/	Cllein			RES	100	J	UNE 22	1 2005	
1	1//		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print) ANLL	KUKRE	TA, M.D.			
) (3001 SOUTH	+ HANOVE		ET P	BALTIMOR	E MAR	LAND	21225	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	A					
	Registr	ar	JUN 2 9 20	05	. H. Ga	will					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 June 23, **Physician** James Forrest King 4:50 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Clinton Southern Maryland Hospital Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 30, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Days Yrs. 88 Director 219 01 9212 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show 10c. City, Town or Location 10b County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantriar must be notified at 1 Tes 2 TNO Director Maryland | Prince Geoprge's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6901 Westchester Court 20748 United States Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No 948 If Yes, Give Year or Dates: 1966 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Air Force Colonel Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Forrest Edward King Ida Behn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mollie King (Daughter) 7228 Benjamin Lane, Owings, MD Sept $\hat{\mathbf{I}}_{\bullet}^{\text{ate}}$ 2005 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Arlington National Cemetery any injury o 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner un Kno-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a so Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 Inpatient 1 🗌 Yes ပ 2/1 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year)

Registrar

Name and ad ress of

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

n who completed cause of death (Item 23a) (Type, Print)

3-4

2005

JUNE, 24, 05

MD 20902

Luckey, Jane

Please Type or Print in Black Indelible Ink	. Assure All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician JANN 2005 June /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON CENTER NURSING HOME If Under 24 Hrs. 8. Date of Birth
Min Month, Day, If Under 1 Year Months Days 5. Social Security Number 250-68-5030 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F 64 Days Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. Stete 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1 ☐ Yes 2 No Director TOWSO MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 HIGRADE 18. Mother's Name (First, Middle, Maiden Sumame) (MN-CKNKNOCKN) 17. Father's Neme (First, Middle, Last) Be LHRISTOPHER MAR 2 of Health and Nitem 27 is mail 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WANDA SIMMONS (DAUGHTER ST. BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: if its any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation √5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses JR. FUNERAL HOME FULTON AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Kinson Dispape /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner en Tro Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of). P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of geath? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. δ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification; To 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely tilled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of de th (Item 23e) (Type, Print) Bluck LTCOU 5601 16aven 31. Dete filed (Month, Day, Year) 32. Registar's Signature 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 11, 2005 4:07 PM M Thomas R. Morris /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Havre de Grace Harford 117 Con Cave Way If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 € M 2 □ F Yrs. Director 219-28-1729 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan rent of Health and Mental Hygiene.
ant: If tem 27 is marked other than "natural", or flems 23a or 28e-f ahow ury or other reauratic avent, the Modical Examine must be notilled at 1 ☐ Yes 2 ☑ No Director Havre de Grace Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 117 Con Cave Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 152-5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify: þ 3 Widowed 4 Divorced **'**52**-**54 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) iron foundry supervisor 12 17 Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Whilma Frances Nichols Thomas Oliver Morris ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 117 Con Cave Way Havre de Grace, MD 21078 Sarah Morris/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State * 4 XDonation 5 ☐ Other (Specify) 21. Shnatura Fun 1 Sanice Lic nsee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caus shock, of heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final entonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 \ Unknown ģ 23e. Did tobacco use contribute to the cause of death? been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. å 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe ueatn? 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 Other: 4 Nursing Home Statesidence 6 Other (Specify) 2 ER/Outpatient P 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After t Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title description 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main St, 281 82. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 9 perte Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 27, ROSIE MAE MILLS JUNE /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1409 E. EAGER STREET BALTIMORE N/A HUNDER 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplece (Stare or Country) |
APRIL 1, 1911 | S. CAROLINA 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 □ M 2X F 220 05 0781 94 Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1409 E. EAGER STREET 21205 U.S.A. or items 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Specify: Specify: 3 XWidowed 4 ☐ Divorced BLACK 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 9th Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. snt: If Itam 27 is marked other then ury or other traumatic event, the Ma College (1-4or 5+) HOUSEWIFE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FORREST HUNT BEULAH TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1561 B. WAVERLY WAY BALTIMORE, MARYLAND 21239 ROSIE MAE MILLS (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JULY 1. 2005 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if eny injury or MARYLAND NATIONAL MEMORIAL PARK LAUREL, MARYLAND 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, Immediate Cause (Final disease or condition resulting in death) **Physician** eci /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Į in the past 12 months? Day 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2/NO 25. Was case referred to medical examiner? 26. Place of Death Check on Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 \(\sum \) Nursing Home 2 No edical Certification: To 1 🗌 Yes 5 Nesidence 6 □Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Dath 28b. Time of 28c. Injury at Work? 28d. A scribe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital filled Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Division of Vital Records,

S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 29

32. Registrar & Signature

Mayas

			1- For State of Maryland		artment of Ho			ene	J. C. O.	1000
	Physici		Decedent's Name (First, Middle, Last) George H. Nash				2. Date of Death		2005	0305a4
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Gilchrist Hospice		4b. City, Town, or TOWSOF If Under 1 Year		h	4c. County	of Death timore	
	Funeral Director		5. Social Security Number 223-32-5690 Usual Residence of Decedent 6. Sex X 2 F 7. Age (In yrs. la	st birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		, 1927	9. Birthplace (Country)	nia
	Maryland -f show	tor		Town or Lo	cation				1	side City Limits
	h with the 3a or 28a st be noti	al Director	10e. Street and Number 5107 Old Court Rd.#112	, u	10f. Zip Code 2 1 1 3	33	10	og. Citizen of W	hat Country?	
980	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show I.a M-cifall Excoller cust be notified at	by Funeral	11. Marital Status 1 Never Married **TMarried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blaci	e - American Ind k, White, etc. Africê	
Maryland 21215-0036	filed within 72 ho Hygiene. ther then "natur: int, It wheales!	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Other	(Give life. I	dent's Usual Occupa kind ol work done d DO NOT use retired) YUCK DY	uring most of wo	rking		siness/Industry	
land ?	ed lata	To Be C	17. Father's Name (First, Middle, Last) Junious Nash			18. Mother's Na	me (First, Middle, M e Boldr		Θ)	
	d 2 sho th and h 7 is ma trauma		19a. Informant's Name/Relationship (Type, Print) A.Marie Kelley/Daughter	230	ng Address <i>(Street a</i> Lodestor	ne Cour	t, West	minist	er, Mo	21158
Baltimore,	50 50		'4 Donation 5 Other (Specify)		sition <i>(Name of</i> natory or other place Mem.Parl			Arbutu	City or Town, Si	ate
Bait	permit Page Department of Important: If any injury or 20029.		21. Signature Funeral Septice Licensee	92	Name and Address	rty Rd.	lie E/H			२१९३ ^५
	Physician	/	234 and Enter the disease, or community the bused the death. shock, or heart failure. List only one cust on each line. Immediate Cause (Final disease or condition resulting in death) a	MOSS), such as cardia	c or respiratory arre	est,	Inten	oximate val Between it and Death
	/Medical Examiner	er	Me to (or as a conseque	¿ Si	mall Cell	Lung C.	arcinoma		Mon	145
8760,	cate be executed by sician and the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence) C. Due to (or as a consequence)							
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown IF FEMALE: 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of dead 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery nth Day	Year
<u>α</u>	quires that the signed by all be detacted	by	Part II. Other significant conditions contributing to death but not resul	ting in the u	nderlying cause give	n in Part I.			ibute to the cau	se of death?
Vital Records,		Completed					24a. Was ar autops perform 1 Yes 2	y yed? d	Vere autopsy fin rior to completic leath?	on of cause of
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	P/Outpatier	nt 3□ DOA Othe		ath <i>(Check only one</i> Home 5□Reside		er (Specify)	spice
Division of		Certification: T	1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \(\)	at	28d. Describe ho	w injury occurre	ed	
Divi	ital or Att irs after d ral Diract led in by		4 Homicide determined 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str City or Town		er or Hural Hout	e Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: Atte completely filled in by the fune	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	on and/or in	vestigation, in my op	inion, death occ	urred at the time, da	ite and place, a		
)	To With	1	29b. Signature and title of certifier Leson Had in D		D 00	061199	25	June,	26,20	
-	りん		and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item Tasan Black Gloz Nor Th 31. Date filed (Month, Day, Year) 32. Reistrar's Signature and Month State Signature and State State Signature and State Sta	23a) (Type, Cha,	Print) Ales ST	Ba/+14	nove in	0 212	04	
k"	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Paistrar's Signatu 32. Paistrar's Signatu	the phy	barle					

			State of Maryland / Department of Heat State Amend Items 23a,25,27,28a-f per Me C845,07	alth and Mental Hygiens 005 21391			
	Physici		1. Decedent's Name (First, Middle, Last) Wendy Ann Olexa	2. Date of Death Month Day Year June 23, 2005 22:51 PM			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death 4c. County of Death			
	Funeral Director			Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 27,1965 Massachusetts			
	Maryland -f ehow lied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MID Prince Georges Fort Washington	10d. Inside City Limits 1 ☐ Yes 2 ☐ NA			
	with the le or 28e Le notii	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?			
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Items 23e or 28e-f ehow event, I're Medical Evarinal must be notified at	by Funeral	Armed Forces? If Yes, specify Cuban, M	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Specify: SpecifyWhite			
Maryland 21215-0036	filed within 72 ho Hygiene. wher then "natur ant, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Finacial Officer	ng most of working			
yland ;		To Be C	17. Father's Name (First, Middle, Last) Gerald J. Olexa In the state of the state	. Mother's Name (First, Middle, Maiden Surname) Frances R. Mead			
	nd 2 shoulth and 27 le m.		Gerald J. Olexa Father 401 Willow Wood	Number or Rural Route Number, City or Town, State, Zip Code) Court Ft. Washington MD 20744			
Baltimore,	permit. Pages 1 a Department of Hea Importent: If item eny injury or othe once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory	June 24,2005 Clinton, MD			
Bal	Depar Impo eny ir		6633 Old Alex	of Facility Lee Funeral Home Kandria Ferry Road Clinton MD 20735			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line. Iron and Ibuprofen limediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	intoxication with complications Approximate Interval Between Onset and Death			
6		caminer	kaminer	kaminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):	
,0928	icate be ex physician a s the burial	edicai Ex		WAS BY MEDICAL EXAMINER			
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year			
<u>α</u>	w requires that been signed b should be deta	by		n Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
Vital Records,		Completed	Anemia, Depression	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No			
of	Attending Physicien: Thr death. ector: After this certificate by the funeral director, pag	ion: To Be	examiner? 1 Tyres 27. Manner of Death 1 Staturel 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury Work?	8. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred iron Subject ingested ibuprofen &			
Division		Certification	3 Suicide 4 Homicide 6 Could not be determined 28. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At home	28f. Location (Street and Number or Rural Route Number, City or Town, State) 401. Willow Wood Ct. Ft. Washington, MD			
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	ledicai	29a. Certifier (Check only one) 1 Tertifying Physicien: To the best of my knowledge, death occurred at the time, (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opini and manner stated.	date and place, and due to the cause(s) and manner as stated. on, death occurred at the time, date and place, and due to the cause(s)			
	with To	×	29b. Signature and title of certifier DU6	ratts Red. Clinton mp20735			
	10	10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUPER A POLE MD 750 SUY 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ratts Rd. Clinton mo20735			
DH	Sta Registi MH 17 Rev 1/2	ar	JUN 2 9 2005 Januar & Species				
			ORIGINAL				

		1	For State Registrar	State of Ma	-	epartme Certifica				Rag. No.	200	5,2130	12
Ph	ysicia		1. Decedent's Name (First, Middle, Las Vernon Beaufor						2. Date of D Month	Day			M C.
P .	Medic	_	4e. Facility Name (If not institution, give			4b. Ci	tv. Town. or	Location of D	June 4	-	County of Dea	5:45 A	
EX	amine	ar	2861 Hollins Ferr				_	ltimore					
Fun Dire	eral ctor		5. Social Security Number 6. Se	X 7. Age	(In yrs. last birt	Yrs. If Uno	der 1 Year ns Days	If Under 24 Hours		ay, Year)		rthplace (State or Fore Jountry) Virginia	вign
yland	=	-	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Lim	nits
death with the Maryland	Delli	cto	Maryland		Balt	imore						1 X Yes 2 □	No
ith th	De Do	Dire	10e. Street and Number				Zip Code				izen of What C		
eath v	must	erai	2861 Hollins Ferr	y Road 12. Was Decedent Ev	ver in U.S.		21230	ispanic Origin	2 (Specify Yes or N		ited S		
ie ie	saminer	by Funeral Director	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			pecify Cuba	n, Mexican, P Specify:	? (Specify Yes or N Tuerto Rican, etc.)		Black, Wh	ite, etc.	
within 72 hours at ene.	Medical	Completed	15. Decedent's Ed (Specify only highest gra-			Decedent's U (Give kind of life. DO NO!	work done o	during most of	f working	16b. Ki	nd of Business	s/Industry	
W 5.	2	Con	12			For	klift	Operat				tributing	
5 28 28 29	a Ve	Be	17. Father's Name (First, Middle, Last)						Name (First, Middl Blanche	e, Maiden			
aryia should and Men	matic	္ရ	Chester Power 19a. Informant's Name/Relationship (7)		19b.	Mailing Addre	ess (Street a		or Rural Route Num	ber. City o	unk r Town. State.	Zip Code)	
C = 44	other traumatic		Mrs. Betty Powers										
altimore, mit. Pages 1 an pertment of Heal portant: If Item 2	othe		20a. Method of Disposition 1		20b. Place of cemeter	Disposition (f	Name of or other place	θ)	Road, Bal	20c. Lo	cation - City o	Town, Slate	
Pages ment of ant: If It	ury o		* 4 □Donation 5 □ Other (Specify)	Cedar							Maryland	
Baltimore, permit. Pages 1 at Depertment of Hea	any inj		21. Signature of Funer I Sympolicen		1113				Brian T. d, Timoni			uneral Srv 3	С.
Physic /Med	lical		23a. Pert ¹ . Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ofications that caused to the cause on each line a. LNL Duy (on as a			4	g, such as car Fail		arrest,		Approximate Interval Between Onset and Death	
Hecords, P.O. Box 68760, The law requires that the death certificate be executed at the has been signed by the attending physicien and	he burial-transit	ical Exa	Sequentially list conditions, if any, loading to kin ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a c. Due to (or as a d.	consequence of								
O. BOX 68 the death certification of the attending plant.	tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopid 5 □ Other	pregnancy (specify)				23d. Date of de Month	olivery Day Year	
dS, P.	Pe	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use of the underlying cause given in Part I.							_/	se contribute to the cause of death?		
Hecords, The law requires to	age 2	Completed							24a. Wa aut per	opsy formed2		utopsy findings availa completion of cause of	
	director, p	Bec	25. Was case referred to medical examiner?					26. Place of	Death (Check only		-		
F & sign	T D	은	1 ☐ Yes 2 No	Hospital: 1 Inpatien		tpatient 3	4	4 🗆 Nursii	ng Home 5		6 □Other (Spe	ecify)	
On Jing Afte	funer	Certification:	27. Manne of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Year) Ir	ime of njury M		yat <br Yes 2 □ No					
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After	lled in by		4 Homicide determined	building, etc.	(Specify)				City or To	own, State)	lural Route Number,	
he Hosp in 24 hou he Funel	pletely fi	Medical	(Check only 2 Medical Exam	ysician: To the best of liner: On the basis of and manner state	examination and	d/or investigati	ion, in my of	pinion, death o	place, and due to the occurred at the time	, date and	place, and du	e to the cause(s)	
To t withi	сош	Σ	29b. Signature and title of certified or cer	Lato.	no		29c. License	5 (0 (§	F	29d. Dat	e signed (Mon	th, Day, Year)	
			30. Name and address of person who of OUG (U.S. Putt	, MD :	3421	Type Print) Bev	1501	Ave.	Balt	ina	re, M	ty, Day, Year) 05 D 2177,)
D.	Sta		31. Date liled (Month, Day, Year)	37 Registrar	's Signature	Goode	,						

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1 5 2	1202
	Physic	ian	1. Decedent's Name (First, Middle, Last) John Elwood Peters, Jr. 2. Date of Death Month Day Year	805 CM
	/Medi	cal	June 26, 2005	102 LW
1	Exami	ner		0.0
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		220-05-8962	lvanja
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. In:	side City Limits
	Marylan	to		□Yes 2⊠No
	72 hours after death with the Maryland natural; or Itema 23a or 28a-1 show orsal Examirer must be routled at	Director	Maryland Baltimore Edgemere 106. Street and Number 106. Zip Code 109. Citizen of What Country?	
	ath wi	rai	2111 Creek Road 21219 United States	
	er des	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Ind Black, White, etc.	fian,
36	urs aft	by F	> 3V Widowed 4 □Divorced Year or Dates: WWII 1 Yes 2X No Specify: Specify:	
9	2 hou	ted	Whi 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry	te
21215-0036	- 20	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)	
	be filed within 72 hours after death with the Maryla nat Hygiene. od other than "natural", or itema 23s or 28s-1 shov event, the Madral Examiner must be poulfied at			ry
anc	d be f	o Be	m	
Maryland	s i and 2 should be filed withir if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Ihe Ma	은	John Elwood Peters, Sr. Martha Lockand Musselman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code))
			Mr. Michael D. Peters (Son) 7715 Iroquois Road Edgemere, Maryland 212	
ore	ges 1 g		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, St	tate
Baltimore,	Pages tment of I tant: if it		'4 Donation 5 Other (Specify) Holly Hill Mem. Gdns. 6/30/2005 Middle River,	MD
Ba	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr 9059.		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222	
			23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx	oximate val Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death) a. A cute intracerebral hemon hage	t and Death
8760,	The law requires that the death certificate be executed as the has been signed by the attending physician and large 2 should be detached for use as the burial transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	years
.O. Box 6	that the death certificated by the attending properties as	Physician/Me	0	Year
ds, P	signed I	þ	Part II. Ditief significant contributing to death but not resulting in the underlying cause given in Part I.	e of death?
Records,	w require s been si should b	Completed	24a. Was an 24b. Were autopsy find	dinos available
Re	The lav	mo du	autopsy prior to completion performed? death? 1	n of cause of
Vital		Be C	25. Was case referred to medical 26. Place of Death. Check and one	0
of V	di is	10	Hospital: Diposition: 3D FR/Outpastion: 3D DOA Other: 4D Nursing Home 5 Providence College (College)	
o u	ding Ph J. After th funeral	iuol:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28b. Time of Injury Work?	
Division	death death stor: / the	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined by the det	Number
Di	after after I Direct	ertil	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C		usø(s)
	ro the	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye	ear)
	> 0		1. Crosson Olenova MD Doco 7632 June 27, 200	3 5
	10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	21222
	Sta Registr		31. Date filed (Month, Day, Year) 32. Agistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician June <u> 26</u> 2005 20:20 PM Ryan Pajak Adam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u> 254 E. Baltimore Street</u> Carroll Taneytown
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) Days 1 M 2 □ F Months Hours Min. Yrs. Director 220-06-4430 24 4-28-1981 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked office than "natural", or itams 23a or 28a-f show other traumatic event. It e Medical Examinar must be motified at 1 ☐ Yes 2 ☐ No Director Maryland Carrol1 Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 254 E. Baltimore Street 21787 Be Completed by Funeral 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) years n/a Mortgage Officer Bank and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) ould be f Milton John Pajak, Jr. Susan Marie Koonts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum <u>once.</u> Milton J. Pajak, Jr. (father) 1567 Bloom Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 6-30-2005 Glen Burnie, MD J. Wayne Osterling 22. Name and Address of Facility McCully-Polyniak Funeral Home, P. A. J. Wayne Osterling 237 E. Patapsco Ave. Baltimore, MD 21. Signature of Funeral Service Licensee 21225 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
M: N u Immediate C inal disease or condition resulting in death) Embo us Pulmono-V Probable **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown been signated Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has funeral director, page 2 : autopsy perfor 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Found at 1 Natural 5 Pending HUNG SELF WITH CABLE 1 ☐ Yes 2 🗷 No 06/26/05 investigation 2020 H 2 Accident after death Director: filled in by the 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 254 E BALTIMERE ST 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 40me TANEYTOWN MD 31787 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa urb and title 2 P0051924 June 27, 2009 To MN 747 3 Mou Charter Rd, Maychester MN 21107 30. Name and add 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Sleeve & Spark

State of Maryland / Department of Health and Mental Hygiene For State Registra**/Amend item Item #15 Per FH G8/47** til 19**219/05** D**9** 14 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 25 25 **Physician** BEULAH MAE PRATT JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** NA BALTIMORE JOSEPH RICHEY HOSPICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Min. (Month, Day, Year) MAY 12, 1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 220–20–0074 **Funeral** Months 1□M 2XF NORTH CAROLINA Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County "natural", or items 23a or 28e-f show solical Examiner must be notified at CATONSVILLE 1 ☐ Yes 2√ No MARYLAND BALTIMORE ō Direct 10f. Zip Code 21228 10e. Street and Number 10g. Citizen of What Country? 801 WINTERS LANE APT. 426 TISA filed within 72 hours efter death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: AFRICAN Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by AMERICAN th and Mental Hygiene.
7 Is marked other than "natur treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARE NURSING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental F CALLIE MOORE AMOS ALEXANDER Pages 1 and 2 should nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other trea QDDCB. 3327 MONDAWMIN AVENUE BALTIMORE, MARYLAND 21216 DAUGHTER DEBORAH C. LOGAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) JULY 1, 2005 RANDALLSTOWN, MARYLAND KING MEMORIAL PARK CEM WYLIE FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BALTIMORE, MARYLAND 21217 638 N. CHMOR STREET Approximate Interval Between Onset and Death 23a. Part1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard filture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) uremia **Physician** months /Medical Due to (or as a consequence of Examiner Renal Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit the death certificate be executed PRI Due to (or as a consequence of) Physician/Medicai Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 DEctopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) the (o 9 Unknown à ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes autopsy 2 No Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 2 No 1 🗌 Yes 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 WOther (Specify) 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Puneral Director: 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tiple of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EutawSt Baltimore 1 State Registrar

			For State Registrar	State of	Maryland / De	partment of ertificate of		•	giene	0 + 0 0 4
			Hegistrar Name (First, Middle)	e, Last)		Ortinoate of	Dealin	2. Date of De	ath	3. Time of Death
	hysici/ Medio/		Helen Romero					June 2	Day Year 5, 2005	8:50 PM M
	Examir		4a. Facility Name (If not institution	n, give street and num	ber)	4b. City, Town	, or Location of De	ath	4c. County of Dea	th
			Keswick Home	0.0	the the section to the triple	If Under 1 Yea	Baltimon		Baltimor	
	uneral rector		5. Social Security Number 362-22-4428	6. Sex 1 ☐ M 2 ☐ F	'. Age (In yrs. last birthd 81 Yrs	Months Day		n. (Month, Da	y, Year) C	thplace (State or Foreign ountry)
	rcotor		Usual Residence of Decedent					12/03/	1923 MI	
ırylan	how	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
e Ma	8a-f	Director	MD Balti	more	Pikesvi	1				1 ☐ Yes 2 No
with t	B Or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•
leath	ns 23	Funeral	7503 Park Heigh		lent Ever in U.S.	21208 3. Was Decedent of	Hispanic Origin?	(Specify Yes or No	United Sta	
after	ar Ital		1 □ Never Married 2 ☑ Marr	Armed Fore	es?∕ ?∑No	If Yes, specify Cu	iban, Mexican, Pue	erto Rican, etc.)	Black, Whi	
Nours a	la la	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:	1 ☐ Yes 2 ☐ N	o Specify:		Specify: Wh	ite
IIIG X IX I 3-0030 be filed within 72 hours after death with the Maryland ital Hygiene.	"natu	Completed	15. Decedent (Specify only highes		(G	cedent's Usual Occ ive kind of work don	e during most of w	rorking	16b. Kind of Business	/industry
withir ene.	than the Ms	dmc	Elementary/Secondary (0-12)	College (1-	4or 5+)	e. DO NOT use retii k Teller	гөа)		Finance	
Hygi	other ent, t	a)	17. Father's Name (First, Middle,	Last)		rierrer	18. Mother's N	ame (First, Middle,	Maiden Sumame)	
land be file fentat Hy	rked IIc ev	To B	Henry Heuser				Edith	LaLinc		
2 should be filed within and Mental Hygiene.	Important: if item 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be multilised at once.	[19a. Informant's Name/Relations		19b. Ma	ailing Address (Stree	et and Number or F	Rural Route Numbe	er, City or Town, State,	Zip Code)
and and	n 27 I ser tra		Monica Green/da	ughter	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ge Court		ville, MD 2	1030
Pages 1	If iter or oth	V s	20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 ☐Removal from S		sposition (Name of rematory or other p	lace)	Jun 29	20c. Location - City or	Town, State
Daltillor Dermit. Pages Department of	tant:		`4 □Donation 5 □Other (Sp			ake Crema		2005	Beltsville,	Maryland
Dall permit. Departr	any Ir		21. Signature of Funeral Service	Licensee M	00986	22. Name and Add Cremation		ral Altern	natives	
			23a. Part1. Enter the disease, or	complications that ca	used the death. Do not	8717 Gree			Baltimore, M	aryland Approximate
-			shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ch line.	_	-		1001,	Interval Between Onset and Death
	sician edical		disease or condition resulting in death)		ras a consequence of):	Age D	einent	in		years
Exa	miner			() 0.000	. 20 2000040000 01/.					V
n n	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequence of):					
acute	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
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certif	been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy				23d. Date of del	iven
death	d for (Iclar	in the past 12 months?	4□ Pregna	nt at time of death	3 □Ectopic pregnan 5 □ Other (specify)	cy		Month	Day Year
) g	by the	hys	9 Unknown	9□ Unknov	vn					
es tha	gned be de	ру Р	Part II. Other significant condition			, , ,		23e. Did to	bacco use contribute to	the cause of death?
equires t	pinoi	ted	14: story of	STYCKES	Aurtic s	temosis	norn	11 1 T	′es 2No 3□Pr	obably 4 ⊡Unknown
wate .	has b e 2 st	ompleted	pressure h	ydro cep	halus			24a. Was a autop	sy prior to	topsy findings available completion of cause of
- E	cate pag	O						perfor 1 Yes		2 No
Sician	ector: After this certificate has by the funeral director, page 2.	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only or		
2 4 E	r this aral di	To :	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 □ Ing 28a. Date of (Month,		ent 3 DOA	4 Vivursing		lence 6 Other (Spec	cify)
and the second	: Afte	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	3	Day Year) Injury	/ Wo	ork? ∐Yes 2∐No		. , ,	
Atte	by th	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place o	f Injury - At home, farm, g, etc. (Specify)	street, factory, office	•	28f. Location (S City or Town	itreet and Number or Ru	ıral Route Number,
rs eft	ed in	Cer			, oto. (opecny)			Oity of 7 on	- Cialo	
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.	To the Funerel Dli completely filled in	Medical	29a. Certifier 1 Certifying (Check only one)	g Physician: To the b Examiner: On the bas and manne	est of my knowledge, de is of examination and/or	investigation, in my	opinion, death occ	curred at the time, d	date and place, and due	to the cause(s)
o the	o the	Me	29b. Signature and title of certifier	and marine	siatou.	29c. Licer	nse number	2	29d. Date signed (Monti	h. Day, Year)
F >1	- 0		M. Ant	hony the	ly, m	0 03	25205		June 27	2005
11	1	1	30. Name and address of person v	who completed cause	of death (Item 23a) (Typ	e, Print)	00 .	<i>(</i>) <i>(</i>)	29d. Date signed (Month June 27 Lito. Md	7. 2
17			W.A-Ril	1	BMC 6	701 N.	Unles	St. Bo	elito. Md	<120 g
	Sta Registr	_	31. Date filed (Month, Day, Year)		gistrar's Signature	21	1.			
	registr	ar		IUN 2 9 200) Stopica	10. 1000				

		1	For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygien	20115	21397
ı	Physicia	ın	1. Decedent's Name (First, Middle, Last) CHRISTOPHER	ROKINSON.	JP.	2. Date of Death Month Di	ay Zoc S	3. Time of Death O O SA M
	- /Medic Examin		4a. Facility Name (If not institution, give)s	/	4b. City, Jown, or Location of Deat		BALTIM	ORE
	Funeral Director		5. Social Security Number 136. Sex	M 2□F 7. Age (In yrs. las	t birthdey) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.		9. Birth Got	nglage (State or Foreign (hjf))
	Aaryland I show ed at		Usual Residence of Decedent 10a. Statul 10b. County	19e-Sity	Town or Location RE			10d. Inside City Limits 1
	with the A sa or 28e-i	Funeral Director	10e. Street and Number	St.	10f. Zip Code (2)/2)/2/	10g. C	itizen of What Co	untry?
036	tiges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If the lime 27 is marked other then "natural", or Items 23s or 28e-f show it if them 27 is marked other then "natural", or other treumatic event, the Macalcal Examir er must be notified at or other treumatic event, the Macalcal Examir er must be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Sees 2 No 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:B	
21215-0036	d within 72 ho giene. Ir then "natur. Ir e Modical I	Completed by	15. Decedent's Edu (Specify only highest grade Elementary(80condary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16b.	Kind of Business/	ndustry Y
Maryland 2	ould be filed within Mental Hygiene. arked other then atic event, It's Man	To Be C	17. Father's Name (First, Middle, Last)	Robinson	SK. Eth	me (First, Middly, Majde	EN Sumame)	
	1 and 2 should Health and Men tem 27 is marke		Ap. Informant's Namy/Helationship (Ty.	reje Modi Ngon	19b. Mailing Address (Street and Number or S	t. BAILOI	or John State, Z	012/8
Baltimore,	Pe mer ent ury		20a. Method of Disposition Purial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liceles	emoval from State	ce of Disposition (Name of nelary, drematory for other place) 22. Name and Address of Facility	1-2005 D	AUCE	Town, Grafe
Bal	permit. Pa Departmen Importent any injury		· Centrill F.	Ealmore .	Do not enter the mode of dying, such as cardia	AVE. ES	160 M	Approximate
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<u>α</u>	uires that n signed b	by	Part II. Other significant conditions con	ntributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco	_	the cause of death?
Vital Records,		Completed				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Vita	Physicien: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ El	Othor	eath (Check only one) Home 5 Residence	6 □Other (Spec	cify)
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	To the Hospital or within 24 hours afte To the Funeral Dire completely filled in the completely filled in the funeral or the f	edical Co			ledge, death occurred at the time, date and place on and/or investigation, in my opinion, death occ			
	To the within To the Comple	Me	29b. Signature and title of certifier	Honding E	MSKVen W5-3	682 Ju	Date signed (Month	1, Day, Year) 262005
	7		30. Name and address of person who co	TOU, Items	23a) (Type, Print) Que, J 560/20	ch Rauen	Blue?	262005 23. Baltions
	Sta Registi		31. Date filed (Month, Day, Year) JUN 2 9 2005	32. Registrar's Signatu				

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ORIGINAL

Director	1. Decedent's Name (First, Middle, La 4a. Facility Name (If not institution, giv 4041 St. Monica	Charles John	D 115				2. Date of Deat			
ner	4041 St. Monica			ing Tr			Month	Day	Year	Z Info of Di
		e street and number)	NOIIII.	4b. City, Town	, or Location		June 2	6, 2005 4c. County		4:37 P
	5 Occid Conside Number 6 5	Drive		Dur	ndalk			Bal	timo	re Co.
	, , , , , , , , , , , , , , , , , , , ,	ex 7. Age (In yrs	s. last birthday	If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day,		9. Birth	place (State or Fi
Irector	213-32-1793 Usuel Residence of Decedent	70	Yrs.				Dec. 24	,1934		yland
rector	10a. State 10b. County	10c. C	City, Town or L	ocation					1	10d. Inside City L
ē	Maryland Balt	imore			Dund	alk				1 🗌 Yes 2
0	10e. Street and Number			10f. Zip Code)		10	g. Citizen of V	Vhat Cou	ntry?
Ta.	4041 St. Monica				212		7 1	Unite		
Funeral	11. Marital Status 1 Never Married 25 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	U.S. 13.	Was Decedent of If Yes, specify Cu	t Hispanic Ori uban, Mexicai	n, Puerto F	city Yes or No- Rican, etc.)		k, White,	can Indian. etc.
byF	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1⊡Yes 25∑N	lo Specify:	:		Specify	: W	hite
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Be	17. Father's Name (First, Middle, Last,				18. MOLTE		ces T.		θ)	
2	Charles J. Rohl		19b. Mail	ing Address (Stre	et and Numb			-	State. Zic	Code)
	Mrs. Johanna Rohl	** *		L St. Mon						
	20a. Method of Disposition	20b.	Place of Disp	osition (Name of matory or other p	lace)	Da	ate 2	Oc. Location -	City or To	own, State
	Y Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif	Removal from State	-	Ht. of Je		em. 6	/30/200	5 Dund	alk,	Maryla:
	21. Signature of Juneral Service Licer	1500		2. Name and Add Ouda-Rucl 922 wise		ral H	ome of i	Dundalk	, In	.c. 222
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edical	(Check only 2 Medical Exer	ysicien: To the best of my kr niner: On the basis of examin								
Med	29b. Signature and title of certifier	and manner stated.	-	29c. Lice	nse number		29	d. Date signed	(Month,	Dav. Year)
	Da Fin to	1 Plan	2		1971	4		(2)	DE	
	30. Name and address of person with	completed cause of death (its	m 23a) (Type	Print)	17 //	1		1/1/	0 -	
	30. Name and address of person who	ILTOIL (TY A	PVMC	LIPYD	IZ A	TEN	Ave	PALT.	her	ma/212

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** THOMAS JOHN RUSH 3:00 A M 27, 2005 June /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3938 Brooklyn Avenue Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days Hours 1 ☑ M 2 ☐ F 214-20-0060 Director 82 Jan. 8. 1923 Marvland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location in then "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Baltimore N/A Maryland 1 ¥Yes 2 □ No Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3938 Brooklyn Avenue 21225 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyglene.
shart: If item 27 is marked other than "naturel", or iteme 23st wit: If item or 21st marked other than "naturel", or iteme 13st up or other traumatic event, the Medical Exercites must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 ☑ No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 XDivorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tri-State Envelope Machinist 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Adam Rush ဥ Margaret Rose Alt 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia M. Cubbage Lain (daughter) 3938 Brooklyn Ave., Baltimore, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State artment cortant: F 6/30/05 Baltimore, Maryland Holy Cross Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) permit Departr Imports any in a 21. Signature of Funeral Server Linensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home, Kevin E Ecker 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** 5ta /Medical Due to (or as a pensequence of) **Examiner** Sequentially list conditions, 1 any, leading to in neutrate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No page 2 should be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 22No certificate 1 Yes To the Hospitei or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 Tes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Valme and address of person oteted cause of death (Item 23a) (TypenPrint) B . Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 Registrar

			1 - For State Registraramen	d item		f Maryland					d Men	ntal Hy	gien Reg. N		ş-m	0 1 /	
	0		1. Decedent's Name (Fi	irst, Middle, La	nst)	5012		<i>1</i> , 0,5 0	ш			Date of De	eath	200	5	Time of Dath	}
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	Exami		4a. Facility Name (If not	institution, gi	ve street and nun	nber)		4b. City, T	own, or Lo	ocation of De				c. County of E	Death	20.30 111	
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ì	Funeral Director		5 377-28-070	2	Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. las 76	t birthday) Yrs.	If Under		Under 24 H Hours M	tin. (Date of Bi Month, Do	ay, Yea	r) 9. 28 Mi	Birthpla Counti	ace (State or Foreign ry) gan	n
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	leath ns 23	era	11. Marital Status	rerrace		dent Ever in U.S.	13 \			anic Origin?	/Cnooity	V 11-		USA		1-4	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23e or 28e-f show avent. If we Mexical Evertiner must be notified at	by Funeral	1 Never Married 3 Widowed 4		Armed For	rces? 2 □ No	1	Yes, special	y Cuban, I	Mexican, Pu Specify:	ierto Ricai	n, etc.))-	14. Race - A Black, V Specify:		tc.	
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Maryland	2 shoul and Me is mark aumati		19a. Informant's Name/				19b. Mailin	g Address (Street and	Number or	Rural Rot	ute Numb	er, City	or Town, Stat	e, Zip C	code)	_
	5 등 2 T		Shirley C.		ts/spous			4.00		ce Wes	stmin	ster	, MI	21157	7		
altimore,			20a. Method of Dispositi 1 ☐ Burial 2 ☐ Cn 1 ☑ Donation 5 ☐	emation 3			e of Dispos etery, crem	sition (Name natory or oth	of er place)		Date		20c. L	ocation - City	or Tow	n, State	
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	ELLI		23a. Part1. Enter the dis	sease, or com	plications that ca	used the death. I	Da Da Do not ente	1timo	of dying, s	D 212 uch as cardi	ac or resi	piratory a	rrest.		Δ.	Approximate	_
	Physician /Medical		shock, or heart fail Immediate Cause (Fina disease or condition resulting in death)	idio. List offiy	a. Sh.	or as a consequen	11	- 273		incer					l le	nterval Between Onset and Death	
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledicai	one)	modicer Exeri	ysician: To the b niner: On the bas and manne	est of my knowled is of examination or stated.	ige, death and/or inve	occurred at estigation, in	he time, d my opinio	ate and place n, death occ	ce, and du curred at t	ie to the c he time, c	ause(s) late and	and manner d place, and d	as state	d. e cause(s)	
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4	Physici /Medi		MONA		HE	REU	BURY		1000	,	2005	1210PM
	Examir		4a. Facility Name (If not institution,	give street and numb			4b. City, Town, o	or Location of D	eath	4c.	County of Death	
			JOHNS HORI				BALTI	MURE			N/A	
	Funeral Director		5. Social Security Number 236-38-9884	5. Sex 1 □ M 2 X F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. (Month, D FEB 5,	ay, Year)	Com	olace (State or Foreign ntry) WV
	pug M		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Le	ocation		/		1.	10d. Inside City Limits
	ith the Marylan or 28a-f show	ō	MD N/A		Balt							1 TYes 2 □ No
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	ath with s 23a or	Funeral Director	3424 East Lomba			- 1	2122		(2)		USA	
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М	Physician		shock, or heart failure. List o Immediate Cause (Final disease or condition	•		- O - A - 1	H.=	44.20 14	W- 5	0		Ohset and Death
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1	N		30. Name in address of person w				4.				3 .	
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		For State		State	of Mai	ryland ,					and M	lental Hy	gier	ne			
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aamiin		ST. AGNES HE	ALTH	CARE				B	al	tim	Ore	2					
Funeral		5. Social Security Number	6. 8	Sex IOXM 2□F		(In yrs. last		If Under 1 Months [Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bit (Month, Da	th ay, Yea	ar)	9. Birthp Coun	lace (State or Fortry)	eign
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e 22	Funerai	11. Marital Status 1 Never Married 2	Married	12. Was Dec			13.	Was Deceder If Yes, specify	Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black,	White,		
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			1- State of Maryland / Department of Haryland / Department / Departm				
	Physici	an	1. Decedent's Name (First, Middle, Last) Al vena W. Sacks		2. Date of Death June 26, 20	2005	3:40 A. M
	/Medic Examin			or Location of Death	00.110 20, 2	4c. County of Death	0.70
			Stella Maris Timonium			Baltimore	
	Funeral Director		5. Social Security Number 217-26-4636 6. Sex 1	Hours Min.	8. Date of Birth (Month, Day, Y February 1	9. Birth	place (State or Foreign Nand
	arytand show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore				10d. Inside City Limits
	or 28a-f	Director	10e. Street and Number 10f. Zip Code			. Citizen of What Cou	
	s 23a	ral	2401 Helmlock Avenue 21214			USA 14. Race - Ameri	non Indian
36	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show avent, it a Medical Extrollegic mat be neitlised at	by Funeral I	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cub 1 Yes, Give 1 Yes, Give 1 Yes 2 Who	an, Mexican, Puerto I	Rican, etc.)	Black, White,	etc.
Maryland 21215-0036	in 72 hou n "natura le Jical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	pation during most of workind)	ng	b. Kind of Business/In	dustry
212	filed withi Hygiene. other than	Com	12 Homemaker			Own Home	
and	8 E 0 8	Be	17. Father's Name (First, Middle, Last) Frederick Weidner	18. Mother's Name Julianna R		iden Sumame)	
aryl	es 1 and 2 should E of Health and Ment item 27 is marked r other traumatic a	²	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street</i>			ity or Town, State, Zij	Code)
	and 2 ealth a m 27 ls		Nancy Sacks /Daughter in law 2927 Bradenbaug				
Baltimore,	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other plate of Cardens of Faith	6/28/0		c. Location - City or T Itimore Mary	
Balti	permit. Pages: Department of H Important: If its any injury or ot		21. Signature of Funeral Service Licensee Christina L. Hilton Leonard J. F. 15305 Harford	ess of Facility RUCK, Inc. I Road Balti	imore Marvla	and 21214	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTED PULMON Due to (or as a consequence of):	ARY DISEAS	SE		Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
ó	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):				
68760,	rtificate be ng physicia as the bur		d				
.O. Box (The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	гу		23d. Date of deliv Month	ery Day Year
<u>α</u>	uires that n signed b ild be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gr	ven in Part I.		cco use contribute to t	he cause of death?
Vital Records,	The law require cate has been sin page 2 should I	Completed			24a. Was an autopsy performe	d? prior to co	opsy findings available impletion of cause of
ital		Be Co	25. Was case referred to medical	26. Place of Death	1 Yes 2 K	No 1 □ Yes	2 N0
of V	Phyaician: this certific ral director,	ို	I Impatient 2 Ervoutpatient 3 DOA	The second secon		ce 6X Other (Speci	y) HOSPICE
	ing After une	ation	2 Accident investigation M 1	nyat ork?]Yes 2 □No	28d. Describe how	mjury occurred	
Division	r it c	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospital of within 24 hours at To the Funeral Completely filled it	edical (29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the temperature of the death occurred at the dea				
)	To the within 2 To tha complete	Ň	29b. Signature and title of certifier 29c. Licen	se number		Date signed (Month,	
	1					-	

State Registrar

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

JUN 2 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

Registrar's Signature

TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Andrew C. Stanger 9.24 PM Jone 2005 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Rosedale Square HOSP, tal Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1√2 M 2□ F Months Days Hours Min 214-22-9650 Director 78 Sept. 26, 1926 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, its Madical Examinar must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Dundalk 1 ☐ Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 7901 St. Claire Lane United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Folces.

1 Yes 2 No
If Yes, Give
Year or Dates Korea filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€No Specify þ Specify. 3XXWidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, Ite Magnes, pines. United States Elementary/Secondary (0-12) College (1-4or 5+) Government Warehouse Manager 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Johanna Wiesner Jacob Stanger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21219 2507 Maple Road Edgemere, Maryland Mrs. Darlene Palmer (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature of Fire Al Service Incensee Holly Hill Mem. Gdns. 6/27/2005 Middle River, MD 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Respiratory disease or condition Eight hours resulting in death) /Medical Due to or as a consequence of): **Examiner** Metastatic Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Three weeks Dise to (or its a consequence of) Examiner The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete has autopsy performed? certificete 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25KN0 or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ◯ No ို 1 Unpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Matural 5 Pending investigation s after decral Director: Alt 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES 0000C June 23 2005 Ji Kim MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR J. KIM 4000 Franklin Square Drive Baltimore Mary land 31. Date filed (Month, Day, Year) JUN 2 9 2005 32. egistrar's Signature State Registrar

Stanger, Andrew

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month lanie 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug. d.d. 9. Birthplace (State or Foreign Country) 1□ M 2∏F **Funeral** 248-56-9252 Months Days Hours Min 10 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant, the Medical Examinar must be notified at NIA 1 Yes 2 No Funeral Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3409 21229 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ounselor 6chool System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be is marked of Pages 1 and 2 should be limothy Williams DO+ Lee Pendarvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health at important: if item 27 is any injury or other trau Sabb-Balto. 3409 W. Franklin St. 21229 daughter MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Sunsat Mem. Gardens July 2, 2005 Charleston, 5 Other (Specify) 4 Donation me and Address of Facility

FREDHILTON PHSS BOLTO. 21. Signature of Funeral Service License 23a. P nt. fit. / the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirty, or lean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Guse (Final disease or condition resulting in death) **Physician** LIVER MONTHS /Medical Due to (or as a consequence of): Examiner ES UP HA GOTAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? page 2 should be detached for Year Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9□ Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Tes 2 8 No 1 🗆 Yes 22 No or Attanding Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) axaminer' 1 Yes 2 Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number von Avris 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · WODAKUS 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June **Physician** 2^{Pay}, 2005 LORETTA ANNETTE SANTMYER 7:30 pm /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health Care of Laurel Prince George's Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 17, 5, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** Months 1 M 2 XX 577-42-9601 86 Director Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at XXYes 2 □ No Director MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 14200 Laurel Park Drive 20707 II.S.A. Funerai Itams ? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 VVo If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes ⊅CXNo If Yes, Give Year or Dates: Specify: Specify: white 3€Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Park & Planning Comm. Grade 12 Supervisor Pages 1 and 2 should be filed nent of Health and Mental Hygi int: If itam 27 ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Schrang Antoinette Germaine P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Counts niece 4024 Pine Brook Rd. Alexandria, VA 22310 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 XX emation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 6/27/2005 Odenton, Maryland 21. Signature of Funeral Service Licenses Donaldson Funeral Home, P.A. Laurel, Maryland / M00770 313 Talbott Avenue 20707 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cerebral thrcmbosis **Physician** minutes resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe q Alzheimer's, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed, 1 ☐ Yes 2 🗵 😿 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4XXVursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo Lo 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

certificate be executed and P.O. Box 68760 attending physician the signed by Division of Vital Records. been To the Hospital or Attending Physician: this in by the funeral After death. after death 24 hours a

Maryland

the

within 72 hours after

Baltimore, Maryland 21215-0036

Medical within 2 State Registrar

auga Ken address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number D 13916

1\(\overline{\text{Lighter}}\) \(\text{Sertifying Physician:}\) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2\(\overline{\text{Medical Examiner:}}\) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

June 23, 2005

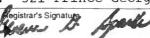
32.

321 Prince George Street Laurel, Maryland William A. Warren, M.D.

31. Date filed (Month) Day, Year) 2005

29b. Signature and title of certifier

29a. Certifie



			For State	State of Maryland /		tment of H			ene No. 2 O O E	
			Registrar 1. Decedent's Name (First, Middle, Last)		-			2. Date of Death	2005	32Time of Delity 7
ı	Physicia		Spencer Ryan	Trusz				June 15	, 2005 Yeer	8:50 AM M
	/Medic Examin		4a. Facility Name (If not institution, give s		4	lb. City, Town, or	Location of Death		4c. County of Deat	h
	LXaniiii	C1	619 Carolyn I			Glen B	urnie		Anne A	runde1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign untry)
L	Director		409-57 - 8688	M 2□F 25	Yrs.	violitis Days	TIOUIS INIII.	July 24,	1979 Ten	nessee
	pur *		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Loca	tion				10d. Inside City Limits
	sho	5	MD Anne Aru		en Bu					1 ☐ Yes 2X No
	28a-1	Director	10e, Street and Number	ilde1 of	- Da	10f. Zip Code		100	. Citizen of What Co	untry?
	3a or		619 Carolyn Ro	ad			.061		USA	•
	ms 2	Funeral	11. Marital Status	2. Was Decedent Ever in U.S.	13. Wa	as Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whit	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Exaction rusal be notified at angle.	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes 2 No	Specify:	nican, etc.)		hite
ğ	2 hou	Completed	15. Decedent's Educ		a. Deceder	nt's Usual Occupa	ation during most of work	unk 16	b. Kind of Business/	Industry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	NOT use retired)		_	
7	ygien ygien t, the	S	12	3			40. 14-15-1-1-1-1-	ne (First, Middle, Ma	data	entry
Ē	be fill	Be	17. Father's Name (First, Middle, Last)					ynn Linde		
2	ould J Mer narks natic	2	Andrew Richard Tr 19a. Informant's Name/Relationship (Ty)		h Mailing	Address /Street			City or Town, State, 2	Zin Code)
<u>a</u>	d 2 sl th and 7 is r traur		Sandra L. Parks-Ti	1				n Burnie,		
ē,	1 an Heal tem 2		20a. Method of Disposition	20b. Place	of Disposit	ion (Name of			c. Location - City or	
ē	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 14 ☑ Donation 5 ☐ Other (Specify)	emoval from State	өгу, сгөппа	tory or other plac) 			
Baltimore, Maryland 21215-0036	permit. I Departm Importar any Injur		21. Signature of Funeral Service Licenses	ade /Director	Sta	Name and Address	ss of Facility Omy Board	1 655 W. I	Baltimore	Street
	402 64		23a. Part 1. Enter the disease, o compli	cations that caused the death. Do		Ltimore,			t.	Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1 - 1	1 1	•	ILIC		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	100	1asto	ma m	4111 70	1 h Q	240
8	Examiner		e-proposition at the state of the	Dao 10 (01 as a consequence	0 01).					,
4	# L	Jer	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):					
	cuted nd ransi	Examiner	that initiated events							
8760,	death certificate be executed e attending physicien and od for use as the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequence	e of):					
9	ifficate g phy as the	edic								
Вох	eath certifi attending f	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel deat		ctopic pregnancy			23d. Date of de Month	ivery Day Year
P.O.	the dery the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 🗆 🤇	Other (specify)				
	res that the de igned by the be detached	문	Part II. Other significant conditions cor	tributing to death but not resulting	in the und	erlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
sp	og De	d b						1 ☐ Yes	200 No 3□Pi	robably 4 Unknown
00	w requir s been si should	Completed						24a. Was an		topsy findings available
Re	The law sate has b page 2 sl	mo						autopsy performs		completion of cause of
ta		0	25. Was case referred to medical				26. Place of Dea	ith (Check only one)	2110	-27
<u> </u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 € No	lospital: 1 Inpatient 2 ER/C	Outpatient	3□ DOA Oth	er: 4 ☐ Nursing H	ome 5 Nesiden	ce 6 □Other (Spe	cify)
0 0	ng Pt fter th neral		27. Manner of Death SNatural 5 ☐ Pending	28a. Date of Injury 28b. (Month, Day Yeer)	. Time ol Injury	28c. Injur Wor	y at k?	28d. Describe how	injury occurred	
Sio	endir eath. or: Al	catio	2 Accident investigation			M 1 🗆	Yes 2 □ No			10
Division of Vital Records,	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	larm, stree	et, lactory, office		28f. Location (Stre City or Town,	et and Number or R State)	urai Houte Number,
u	Hospital 24 hours a Funerel I		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge	ge, death o	occurred at the tir	ne, date and place	, and due to the cau	se(s) and manner as	s stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certification completely filled in by the funeral director.	Medical		ner: On the basis of examination a and manner stated.				rred at the time, date	e and place, and due	e to the cause(s)
	To the within To the Comp	Ž	29b. Signature up 1 little of certifier	1000		29c. Licen	number	7	d. Date signed (Mont	
)			(most/	1/60			3/15/		June 21	2005
			30. Name and address of person who ex	mpleted cause of death (Item 23a	(Type, Pi	rint)		n -	01.0	12005
			31. Date filed (Month, Day, Year)	32. Registrar's Signature	30	5 40	SO 1 tay	41.70	(HO) WAY	114.404
	Sta Regist		JUN 2.9 2005	Sz. negistrai s Signature	back			•		
	ricgist		JUN & 3 2003	J. S. Markey No. P.	11111111111111					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Non 2. Date of Death 1. Decedent's Name (First, Middle, Last) D. homas 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Memoria Union 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 M 20 F 11.11.1930 215. 28.3226 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1- Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5834 4SA 21215 Avenue ui 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HealthCare lechniciar lyrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna Easley Donald Kay bord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or State, Zip Code) Jonne N. Gladney Daughte 35 23 Sa. Method of Disposition (Name of Syssex Rd B. 16 MD 21207 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-28-05 Park Balto. MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility 8 728 Liber 1 Rd 2 and a listum mp 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call on each line. z1133 Approximate Interval Between Onset and Death jocardial Immediate Cause (Final 16 hour disease or condition resulting in death) Due to for as a consequence of) aspination Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ongestive Due to (a as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, for use as the the detached signed t 1 be deta page 2 should certificate has or Attanding Physicien: tor: After this certific the funeral director,

Hospitel

To the

Physician

/Medical

Examiner

Funeral

Director

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Examiner

Baltimore, Maryland 21215-0036

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed 25. Was case referred to medical ဥ 27. Manner of Death Medical Certification: death. after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Angela mislousky
B1. Date-filed (Month, Day, Year) 201 32. Regist 's Signature

2005 ▶

29b. Signature and title of certifier

AT2438946

29c. License number

29d. Date signed (Month, Day, Year)

University Pkwy Baltimore, MD 21218

mn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. N.2 A A 2 Oate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician hornon 26 200)une secnord /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mothe CI-105 pita If Under 1 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 5. Social Security Number 5'70 - 36 - 326 6 Sex 8. Date of Birth (Month, Day, Funeral Days Min Hours 5 1 M M 2 □ F Washington, D Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r then "netural", or Items 23a or 28a-f show the Medical Examinatings by rediffed at 1 Yes 2 No MD Director 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? SHITE NITECT Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: BLACK Saltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Completed by I 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Is marked other then ruck Driver treumetic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (and Mental OVENCE hornton 2 19a. Informant's Name/Relationship (Type, Print) (501) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important of Health at Important: If item 27 Is I eny injury or other transpore Big Back Glen Durnie MD. 21061 lHomas 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7/5/05 Riverdale, MD. Riverdale Crematory ' 4 □Donation 5 □ Other (Specify) 420 It Street N.F. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Wash, DC. ZOOOZ MOII Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brainsten Physician days /Medical Due to (or as a consequence of): Examiner Elgo for arte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed by the attending physician and tached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown been signed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2 No 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mar 31. Date filed (Month, Day, Year) Signature State JUN 2 9 2005 Registrar

Michael Thompson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-04310 State of Maryland / Department of Health and Mental Hygiene

1- State Unpend Item 23a&27 per me G845-7-26-05 tas
Registrar Registrar RPD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** June 25, THOMPSON MICHAEL ANTIONE 1130 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Samaritan Hospital NIA Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**Д** М 2□ F 22 219-02-855 Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1. Yes 2 □ No Directo MARVLAND 10e. Street and Number 10f. Zip Code 100. Citizen of What Country? 42 VISTA USAI by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. illed within 72 hours after 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: BLACK Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or othar traumatic evant, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE OVED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMPSON WHITE GERNARD 2 ブノム 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VISTA BALTO, MD. 21206 (MOTHER) JILL WHITE important: if item any injury or othan Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State HILL CEME 7-02-05 BALTIMORE ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN JR. FUNERAL Lyounce ULTON AYE. 23a (Part1. Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asthma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed the burial-tran Due to (or as a consequence of) 68760 physician Physician/Medical as IF FEMALE nse s 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year jo Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☆ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division After Hospital or Attending 1 Xvatural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one)

State Registrar

Mer

and manner stated.

144

29c. License number

OCME

June 26, 2005

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Morte

111 Penn Street Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) 32. Registras Signature JUN 2 9 2005 >

To the within 2 To the

		•	For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of <i>rtificate o</i>		and Menta		ne •200	5 2	
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					ENTRE	-	ar If Under		te of Birth		N/A	(State or Foreign
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	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d.	Inside City Limits
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Baltimore,	permit. Pag Depertment Important: I any Injury o		21. Signature of Fureral Service Li		2	2. Name and Add	dress of Facility	У				
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Box	The law requires that the death certificate be executed tte has been signed by the attending physician end oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	4 Pregnar	h 2 Fetal death 3 ht at time of death 5	□Ectopic pregnal □ Other (specify)				23d. Date Mont	of delivery th Day	y Year
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			1 - State Registrar		artment of Health and Martificate of Death		2005 21412)
			Registrar 1. Decedent's Name (First, Middle, Last)		inoute of Bount	2. Date of Death	3. Time of Death	
	Physici /Medio		Gerhard J. Tabor			June 1	.6,2005 Year 12:50PM	M
	Examir		4a. Facility Name (If not institution, give street and no	mber)	4b. City, Town, or Location of Death		4c. County of Death	
			7510 Milligan Lane		Clinton		Prince George's	
п	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 □ F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Foreign Country) 1949 Vienna Austria	
			Usual Residence of Decedent			1000. 20,	,1949 Vielilia Austria	
	irylan show	_	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limit	
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	with the	Funeral Director	10e. Street and Number 7510 Milligan Lane		10f. Zip Code 20735	10	g. Citizen of What Country? U.S.A.	
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9	or ite	Fur	If X as G	2 No 1070	If Yes, specify Cuban, Mexican, Puero 1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Black, White, etc.	
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Maryland	and and is m		19a. Informant's Name/Relationship (Type, Print) Ernest Tabor (Father)		ng Address <i>(Street and Number or Ru</i> Spring Lake Drive			
d)	feall feall m 2		20a. Method of Disposition	20b. Place of Dispo		n . T .	Oc. Location - City or Town, State	-
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aH:	partmoortar		21. Signature of Fune al Service Lice				Home, Inc.	
m	Depa Impo eny ir		MANUTAL	700153 E			Road Clinton, MD2073	5
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not ente	ter the mode of dying, such as cardiac	or respiratory arres	Interval Between	
}	Physician		Immediate Cause (Final disease or condition	Leart	Failure		Onset and Death	
	/Medical Examiner		resulting in death) Due to	(or as a consequence of):	¿ Cardivussul			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence of):	C COMMO CHAIM	a alx	euse	
,	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c				>	
o	a exec an an urial-tr			(or as a consequence of):				
8760,	The iaw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lcal	d					
9	eath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23c If yes or	itcome of pregnancy			C2d Data of delivers	
Вох	atten	clan	in the past 12 months?	birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
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	igned be det	by P	Part II. Other significant conditions contributing to		nderlying cause given in Part I.		acco use contribute to the cause of death?	
ord	w require been signal		1010141016 2	cherosis		1 🗌 Yes	2 No 3 Probably 4 Unknow	/n
Records,	e iaw r has be je 2 sh	Completed				24a. Was an autopsy	24b. Were autopsy findings availab prior to completion of cause of death?	le f
E H	icien: The certificate has sector, page						No 1 ☐ Yes 2 ☐ No	
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 \sum No Hospital:	Inpatient 2 ER/Outpatie	Other	th (Check only one,	ce 6 ☐Other (Specify)	
of		n; To	27. Manner of Death 28a. Date	of Injury 28b. Time of		28d. Describe how		
ion	ttending P death. ctor: After i y the funera	atlo	2 Accident investigation	nth, Day Year) Injury	M 1 Yes 2 No			
Division	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Plac determined build	e of Injury - At home, farm, st ling, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)	
	To the Hospitei or Attent within 24 hours after deatl To the Funerei Director: completely filled in by the		Constitute Developing Developing To be	- bast of any knowledge, death	h	and due to the one	nan/a) and maggar as stated	-
	To the Hospitei within 24 hours of To the Funerei completely filled	Medical	(Check only 2 Medical Examiner: On the		h occurred at the time, date and place vestigation, in my opinion, death occu			
	ro the within ro the comple	Me	29b. Signature and title of certifier	· ·	29c. License number	290	d. Date signed (Month, Day, Year)	
	,- 0		* Stuff 1) Sverly	n mo	ロンナイイ	-	06-17-2005	
	1/41		30. Name and address of person who completed car					350
	121,		Stuart J. Goodman, MD	7501 Surratt	s Rd. # 309 Clint	on, Md. 2	20735	_
	Sta Regist		31. Date filed (Month, Oay, Year) 32.	Registrary Signature	Soule			
			-31.4 0 400	PRREUM N				

			State of Maryland / De	epartment of Health and Mental Hygiene
			For State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death Reg. N2 0 0 5 2 1 3
П	Physicia		Elfrida Torres	June 26, 2005 4:15amM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			Heritage Center	Dundalk Baltimore Bulli More Baltimore Bulli More
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min. (Month, Day, Year) Country)
	ם		Usual Residence of Decedent	
	arylan ehow	ž	10a. State 10b. County 10c. City, Town of Balti MD n/a Balti	
	28e-1	ecto	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	3a or	i Di	113 S. Potomac St.	21224 USA
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland entment of Health and Mental Hygiene. ortent; If Item 27 is marked other then "natural", or Items 23s or 28e-f show Injury or other treumatic event. If a Medical Evention must be notified at lajury or other treumatic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 Moore 1 □ Yes 2 Moore 1 □ Yes Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1⊠ Yes 2□ No Specify: Puerto Rican Specify: White
2	72 hou natura	eted	15. Decedent's Education 16a. D (Specify only highest grade completed) ((ecedent's Usual Occupation Sive kind of work done during most of working te. DO NOT use retired) 16b. Kind of Business/Industry New Brunswick
2	ne. hen "i	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	New Brunswick counting Clerk Board ofEducation
d 2	e filed within al Hygiene. I other then ' vent, I' e Me		2+ AC	18. Mother's Name (First, Middle, Maiden Surname)
lan	Mental Mental arked o	To Be	Luis E. Torres	Ana Marie Martinez
, Maryland 21215-0036	and 2 should falth and Men 127 Is marke er treumatic		5011	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 S. Potomac St. Baltimore, MD 21224
Baltimore,	Pages 1 and 3 nent of Health of; If Item 27 iry or other tr			isposition (Name of crematory or other place) Wn Date 20c. Location - City or Town, State 6/29/2005 Baltimore, MD
Balti	permit. Pages Depertment of I Importent; If Ite any Injury or o'		21. Signature of Funeral Service Licensee Malia A. Dunner	22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St. Baltimore, MD 21224
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) a. Due to (or as a consequence of the condition of the consequence of the condition of the c	Approximate Interval Batween Onset and Death DEMENTIA Approximate Interval Batween Onset and Death EAR
,092	icate be executed physician and sthe burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen	
.O. Box 68	The law requires that the death certificate to the has been signed by the attending physic bage 2 should be detached for use as the bage 2.	Physician/Medica	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3 ☐ Ectopic pregnancy 23d. Date of delivery Month Day Year
s, P	es that igned to be det	by	Part II. Other significant conditions contributing to death but not resulting in t	
ord	v requir been s should	eted	DIAGE C MELLITI	
Vital Records,		Completed	DIADELES MELECTO	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Vita	Physicien: T this certificat ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outg	26. Place of Death (Check only one) atient 3 DOA Cther: 4 to virsing Home 5 Residence 6 Other (Specify)
o o	ing After une		27. Mannes Death 1 atural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Tir	ne of 28c. Injury at 28d. Describe how injury occurred
Division	ten leat tor: the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Hospite 4 hours Funerel ely fille	Medical C	29a. Certifier (Check only one) 1 Vertifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
)	To the within 2 To the complet	M	29b. Signal to title of certifier	29c. License number D14160 JVNE 27, 2005
	X		3d Name and address of person and demokratichers of death (Item 129) (I	ARYLAND 21225
	Sta • Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Dr	Regist	4 6	JUN 2 9 2005	no will
טר	17 116V 1/2		ORIG	INAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year VERSHOUA 0730 A M /Medical JUNE 27 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTH WEST HOSPITAL RANDALLSTON N BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) OCT.15,1919 **Funeral** 9. Birthplace (State or Foreign Country) UKRAINE Days 1 ☐ M 2 ☐ F Hours Min Director 220-31-7487 85 Usual Residence of Decedent with the Maryland 10a, State 10c. City. Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 1450 BEDFORD AVENUE #514 21208 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Never Married ☐Yes 2 No Yes, Give 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No à Specify: WHITE 3 Widowed 4 Divorced Specify: Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Δ TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **BORUCH BROYTMAN** SHAYNA (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tree EUGENE VERSHOV / SON 149 CAROLSTOWNE ROAD - REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM | 6/28/2005 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician myo Cardial lay inter ction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last multi -or un Examiner Due to (or as a consequence) physician and s the burial-transit The law requires that the death certificate be executed hematona etro en nexi Due to (or as a con equence of): P.O. Box 68760, Physician/Medical as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Day signed by the a 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9☐ Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2 No 1 Yes 1 Yes 2X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Certification; To Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury o the Hospital or Attendi within 24 hours after death, to the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide lilled 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29h. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D0059736 MD Dutton 27 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOT HAVE ST MCLT 10 11 111 おおんだ。左 JUN 2 9 31. Date filed (Month 32. gistrar's Signature State 2005 Registrar

l			_ FOI	epartment of Health and N Dertificate of Death	Reg	ene . No 2005	21415
	Physici		1. Decedent's Name (First, Middle, Last) Leila Wormley		2. Date of Death Month June	Day Year 2005	3. Time of Death 1:24 P M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June	4c. County of Deat	1
			Bon Secours Hospital	Baltimore		N/A	
	Funeral Director		777 700	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	nplace (State or Foreign untry)
	show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	1			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show final be rufffind at	Funeral Director	MD 10e. Street and Number	10f. Zip Code	100	J. Citizen of What Co	1 ▼Yes 2 No
	23a or	Ē	1802 Ruxton Ave	21716		USA	,
	ter death	ınera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian, a, etc.
980	hours after tural, or its	by	1 □ Never Married 2 □ Married 1 □ Yes 2 12 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	lack
5-0036	72 hours "natural",	eted	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ing 16	b. Kind of Business/	Industry
2121	within jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	House Keeper	-	Donestic	J
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Importants if item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, if a Medical Evertinal reast be notified at once.	To Be C	17. Father's Name (First, Middle, Last) Luchious Hudnall	18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
Man	d 2 sho h and l 7 is me traums	_		Mailing Address (Street and Number or Rur	0 1	BALTO L	(ip Code) 10 21229
	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition 20b. Place of I	71112000-1-77	1,000	c. Location - City or	
altimore,	Page nent o ant: If ury or				1-05	BAGO.	
Balt	permit Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee Calta C. Woulden	22. Name and Address of Facility Canton C. Douglass	Funerals	ervice-By	OI McCulloh St LUTO. MD 21217
			23a. Part1. Enter the disease, or complications that cansed the death. Do no shock, or hear failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of	rei			
	Examiner		PURMINAN	EMBOLISM			
	pe sit	niner	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying				
o,	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	is it it it			
8760,	ate hy the	dlcal	d				
Вох 6	death certific e attending p id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
P.O. Bo	0 D	by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
	requires that the een signed by th nould be detache	by Pr	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to	
ord					1 ☐ Yes		obably 4 Unknown
of Vital Records,	e fa has	Completed			24a. Was an autopsy performe	d? death	topsy findings available completion of cause of
tal	ician: Th certificate rector, pag	ø	25. Was case referred to medical	26. Place of Deat	h (Check only one)	No 1 Yes	2 No
Ž	Physician: this certific ral director,	To B	examiner? 1 🔀 Yes 2 □ No Hospital: 1 □ Inpatient 2 💢 ER/Outp			ce 6 □Other (Spec	city)
o uc	Jing P. After t funera	ilon:	Taldial Salistiding	me of ury M 28c. Injury at Work?	28d. Describe how	injury occurred	
Division	al or Attending F s after death. Il Director: After ad in by the funera	ificat	Maccident investigation 3 Suicide 6 Could not be determined 3 Suicide 10 Suicide 28e. Place of Injury - At home, farm		28f. Location (Stree	et and Number or Ru	ral Route Number,
Ö	s after al Dire	Certification;	4 Homicide determined building, etc. (Specily)		City or Town, S		mort up
	To the Hospital or Attending Phye within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral difference of the funeral differenc	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, 25 Medicel Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month	
	1		Wayne The Hall MO	OCME	J	une 25, 20	005
1	11		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) 111 Penn Stree	t Baltim	ore, Mary	land 21201
	Sta Registi		31. Date filed (Month, Day, Year) 2. Registrar's Signature	gents)			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 Leonard Loftis June 25, 11:15 A. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles 10960 Beechwood Court Waldorf 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**№**M 2□F 78 July 5, Georgia Director 579-26**-**6365 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r 28a-f show 1 XYes 2 No Maryland Charles Woldorf Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with and Mental Hygiene, and Hetal Hygiene, and It Item 27 is marked other than "natural", or Items 23a or Jry or other traumatic event, I'm Mudical Example or Insulate. United States 20601 10960 Beechwood Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 GYes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Facilities Manager U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Richard Stephens G. Voil Webb ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10960 Beechwood Court Waldorf, MD 20601 19a. Informant's Name/Relationship (Type, Print) Mathilde Webb/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Georgetown University
Medical Center Date 20c. Location - City or Town, State 20a Method of Disposition June 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 2005 4 Donation 5 ☐ Other (Specify) Washington, D.C. 22. Name and Address of Facilit Columbia Mortuary Services, Inc. 21/Signature of Funeral Service License P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 ☐ Other (specify) o. the detached 9 Unknown á ۵ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 4 Orknown 1 🗌 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res page 2 1 ☐ Yes certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home ို 2000 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) 1 Yes 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Ca 6 who completed cause of death (Item 23a) (Type, Print) KR 151 H 30. Name and address of person 0 0 0 31. Date filed (Month) 32 Sgistrar's Signature State 2005 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrer Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:55A M June 24, 2005 Albert Nelson Williams, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Marlboro Prince George's 10009 Crain Highway S. 8. Date of Birth (Month, Day, Year) Nov. 20,1942 Birthplace (State or Foreign Country)
 N A 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1₽M 2□F 220-40-4324 62 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intern 57 lems 23e or 28e-f show ant: If item 27 la marked other than "natural", or Items 23e or 28e-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County orant: If item 27 Ia marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be redified at 1 ☐ Yes 2 No Upper Marlboro, Maryland Marvland Prince George's Director 10g. Citizen of Whal Country? 10f. Zip Code 10e. Street and Number 20772 U.S.A. 10009 Crain Highway S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ā Year or Dates: 11. Marital StatuUknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHite þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Verizon (Ret.) Unknown
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown ဝ 19b Mailing Address (Street and Number of Rural Boute Number, City or Town, State, Zip Code)
MeIwood Church of the Nazarene
6906 Woodyard Rd Clinton, MD 20735 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 la any Injury or other trau 900. John W. Nielson (Pastor) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June Day 8, 20c. Location - City or Town, State □ Burial 2 □ Cremation 3 □ Removal from State 2005 Southern Memorial Gardens 4 ☐Donation 5 ☐ Other (Specify) Dunkirk, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral 9 6633 Old AlexandriaFerry RD Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date sighed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 52 1 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 Old Line Center, Robert Pace, MD #302 Waldorf, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Marylan		artment rtificate			ind M		Reg. No 2 0	05	21418
	Physici	an	Decedent's Name (First, Middle, Last)	1			VOLIC	⊏ ₩		2. Oate of De.	27, 20	Year	3. Time of Death 12:20 P M
	/Medic	al	HERBERT 4a. Facility Name (If not institution, give s	treet and number)	•		YOUS	Location o	f Death	OUNE		ty of Deeth	1
	Examin	ier	22 CAVESWOOD LA					INGS		.S		BALTI	MORE
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I		If Under	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birth	place (State or Foreign intry)
	Director		216-24-1019 X	M 2□F 76	Yrs.		16.			MAY 25	, 1929		. MD
	land ow		10a. State 10b. County	10c. City	, Town or Lo	ocation							10d. Inside City Limits
	a-f sh	to	MD BALT	TIMORE	OWI	NGS M	ILLS						1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip	Code	011	4.5		10g. Citizen of	What Cou	
	sath w	erai	22 CAVESWOOD LAN	NE 12. Was Decedent Ever in U.	S 13 1	Was Deced	ent of His	211		ocity Yes or No	- 14. Ra	ice - Ameri	USA ican Indian,
36	be filed within 72 hours after death with the Maryland its Hygiene. al Hygiene do do other than "natural", or items 23a or 28a-f show do ther than "natural", or items 23a or 28a-f show event, the Medical Evantiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	}	If Yes, speci		Specify:	, Puerto	ecify Yes or No Rican, etc.)	Spec	ack, White,	
21215-0036	72 hou	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual	l Occupa	tion	of worki	na	16b. Kind of I	Business/Ir	ndustry
2	ithin 7 ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of worl DO NOT use		, , , , , , , , , , , , , , , , , , ,		9	MEDI	CINE	
2	lled w Hygier ther th		17. Father's Name (First, Middle, Last)	5+	PHY	SICIAN		18. Mothe	r's Name	(First, Middle,	MEDI Maiden Suma		
Maryland	ed tal	To Be	SAMUEL		YOUSE			BL	ANCH	E		0L	INICK
Ma	d 2 sh th and th sum traum		19a. Informant's Name/Relationship (Type STELLA YOUSEM /			_				WINGS N			
ē,	s 1 and f Health item 27 other to		20a. Method of Disposition	20b. P	lace of Dispo	sition (Nam	e of			Pate	20c. Location		
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Balti	permit. Peges 1 and 2 should Department of Health and Men Important: If item 27 is marke ery injury or other traumatic 9068.		21. Signature of Funeral Service License	7.00	> 22	2. Name and 8900							., INC. , MD 21208
- 3	Ø. 0.8		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death e cause on each line.	n. Do not ent	er the mode	e of dying	, such as	cardiac c	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Me tas both	e tr	- consi	600	1 co	U	conce	nona.		Onsot and Boat
4	/Medical Examiner		resulting in deality	Due to (or as a consequ	uence of):								
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m	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal		Ectopic pre Other (spe						lonth	Day Year
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	w requires tha been signed should be dei	þ	Part II. Other significent conditions con	tributing to death but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	./		the cause of death? bably 4 Unknown
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u O	ding F h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M	8c. Injury Work 1 □ Y	al ? ′es 2.∐.l		Zou. Describe i	low injury occu	iiiou	
Division of Vital	if or Attending affer death. Director: After I in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory,	, office			28f. Location (S City or Tov		ber or Rur	al Route Number,
_	Hospita Hours Funeral	Medical Co		sician: To the best of my kno ner: On the basis of examinal and manner stated.									
	within 2 To the comple	We	29b. Signature and title of certifier			29c.	. License	number			29d. Date sign	ed (Month,	Day, Year)
1	1//		· // //				019	914	r		6/2	7/01	-
1	U		30. Name and address of person who co	ripleted cause of death (Item	23a) (Type,	Print)		,	,	11	4 1		
1			31. Date filed (Month, Day, Year)	32 Benistrar's Sinns	FA	L hu	2 .	_ ul	tu	ville	nd	2169	3
	Sta Registr		JUN S	nepleted cause of death (Item 5 10 7 5 32. Registrar's Figna 2 9 2005	113 11 186	A Maria	ANT	19					

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Dea	ath	Reg	· የያበበ5	211.10					
			1. Decedent's Name (First, Middle, Last) VICTOIZ C. ARNOUD 2. Date of Death Month Dey Year									
	Physici /Medic		Victor Claude Arnold	J	June 17	, 2005 Year	3:04 PM					
1	Examin		4a Fecility Neme (If not institution, give street and number) 4b. City.	ty, Town, or Loc	ation of Deeth	4c. County of De	eth					
			Northampton Manor Inc. Fre	ederic	k	Freder	ick					
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea	Inder 24 Hrs.	8. Date of Birth	(ear) 9. B	irthplace (State or Foreign Country)					
Çr	Director		232-09-1288 1XI M 2 F 85 Yrs. Months Days Hou	8. Date of Birth (Month, Dey,) Pec • 19	,1919	VÄ						
	ylanc 100%		10a. Stete 10b. County 10c. City, Town or Location				10d. Inside City Limits					
	Mar	ō	WV Tucker Davis				Yes 2□No					
	28 T	Director	10e. Street end Number 10f. Zip Code		100	. Citizen of What C	Country?					
	wite 8	0	Fairfax Avenue 26260			USA						
	doath	Jer	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	ic Origin? (Spec	cify Yes or No-	14. Race - Am						
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours affer doath with the Maryland Department of Health and Mantal Hyglene. Department of Health and Mantal Hyglene. The Maryland of them 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, fre Madical Examiner must be notified at once.	by Funerai	1 Never Married 2 Married 1 1 Yes 2 No If Yes, Specify Cuban, Mex 1 Yes, Give 1 Yes 2 No Specify Cuban, Mex 2 No Specify Cuban, Mex 1 Yes, Give 1 Yes, Give 1 Yes 2 No Specify Cuban, Mex 1 Yes, Give		tican, etc.)	Specify: W						
Ŏ	2 ho	P	15. Decedent's Education 16e. Decedent's Usual Occupation		16	b. Kind of Busines	s/Industry					
2	7 uic	pie	(Specify only highest grade completed) (Give kind of work done during not life. DO NOT use retired) (Give kind of work done during not life. DO NOT use retired)	most of working	g							
2	d wit	БО	12 Coal Miner			Coal						
פ	other of the	Be Completed	17. Father's Name (First, Middle, Last) 18. Mo	Mother's Name	(First, Middle, Ma	iden Sumame)						
<u>a</u>	should be nd Mantal marked o	10 E	Wally Arnold De	ella H	larper	Arnold						
ary	Short Short		19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number 19b. Mailing Address (Street end Num									
Σ	end 2 saith a n 27 is		JoAnn Pregley/stepdaughter 3363 Stuart Ct	ct. Ada	mstown	, MD 21	710					
ē,	s 1 e	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 20	c. Location - City o	r Town, State					
Ë	Pages nent of int: If the iry or o		1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Davis Cemetery	06/	20/05	Davis,	WV					
	artm ortar	ŀ	21. Signature of Funeral Service Licensee // 22. Name and Address of Fa	Facility	<u> </u>		***					
Ä	Dema Impo any It		least linkle Fund P. O. Box	eral H 186 Da	lome, I nvis, W	nc V 2 6260						
	$\pm T$		23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	ch as cardiac or	respiratory arres	t,	Approximate Interval Between					
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	/Medical Examiner		Immediate Cause (Final disease or condition a. ALZHOMORS (CND STA	TAGE			10055					
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Вох	ath co	an										
o ·	law requires that tha death ce as been signed by the attandi a 2 should be detached for us.	Sic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I.	23b. Did toba	cco use contribut	e to the cause of death?					
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ခ	has b	힐					of death?					
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ita I	clan: entific ector,	Be	examiner?	Place of Death ((Check only one)							
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_	ng P fter t iners	ë	27. Menner of Deeth 1 ☐ Neturel 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury		3d. Describe how	injury occurred						
<u>S</u>	endl eath. or: A the fu	cati	2 ☐ Accident investigation M 1 ☐ Yes 2									
Division of Vital Records, P.O.	r Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	If. Location (Stree City or Town, S		Rural Route Number,					
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	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, paga:	edicai	29a. Certifier (Check only (
	the the upper		and manner stated. 29b. Signature and title of sentitor 29c. License numbi	hor	204	. Date signed (Mor	th Day Year)					
	1 v v v	-	29b. Signature end title of equities 29c. License number		230							
				1 / 1		6/221	ω ₂					
	- 6		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)									
	5		RICHARD L. GOLGH MD PO BOX 328 WAL	LK6125011	TE WD	2:793						
	Stat • Registra	e	31. Date filed (Month on Year) 32. Pigistrar's Signature									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			State of	•	Certificate of		Reg	. №2005	211.20				
	Physician	F.(1105)	lle, Last)	Bu	ırroughs		June 0	2005 4 2005	06:37				
Ų.	/Medica Examine	An Cantita Mana /// and incitively	-	nber)		4b. City, Town, or Lo Capitol		4c. County of Death Prince	George's				
Ī	Funeral Director	5. Social Security Number 578–40–7392	6. Sex XX 2□ F	7. Age (In yrs. last bin 74	thday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y 08/30/19	(ear) 9. Birth Coo 30 Wash	nplace (State or Foreign untry)				
	ν.	Usuel Residence of Decedent 10a. State 10b. County	/	10c. City, Town	n or Location			10d. Inside City Limits					
	8a-f s	MD Prince	e George	Capito	1 Heights				1 ^½ Yes 2 □ No				
	ath with the 23s or 2 unit be no	10e. Street and Number 400 Rollins Ave			10f. Zip Code 20743			USA					
020	urs after dec	11. Marital Status 1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	rried Armed For	2□No 1951-	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh					
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. To Re Commissed by Elipsoria	15. Deceder (Specify only higher Elementery/Secondary (0-12) 1 2	nt's Education est grade completed) College (1	16e.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire lerk	pation during most of work d)	ring P	b.Kind of Business/li rivate Aut ental Comp	to				
d 2	be filed tal Hygie d other event, to	17. Father's Neme (First, Middle,	, Last)			18. Mother's Name	e (First, Middle, Ma.						
/lan	Mental Hyginaric event, Ito Be Co	Ernest J. Burn	coughs			Dorothe	a Feis						
Aan	2 should and Men is marke reumatic	19a. Informent's Name/Relations	ship (Type, Print)	19b.	Mailing Address (Street	t and Number or Run	ei Route Number, C	City or Town, Stete, Z	ip Code)				
	1 and 1 Health em 27 other tr	Myrna Graham/Co	ousin	20b. Place of	05 Ritchie Road Disposition (Name of y, crematory or other pla	d,Forestvill		7 c. Location - City or T	own, State				
mon	Pages ent of nt: If it	1 ☑ Burial 2 ☐ Cremetion		state		1	/21/05 Che	eltenham, MD					
Myrna Graham/Cousin 2205 Ritchie Road, Forestvil 20a. Method of Disposition (Name of cemetery, crematory or other place) 1\(\text{M}\) Burial 2 \(\text{Cremetion} \) 3 \(\text{Removal from State} \) 4 \(\text{Donation} \) 5 \(\text{Other (Specity)} \) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. The control of t								Funeral	L Home, inc				
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Division		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 206. Plece	of Injury - At home, far g, etc. (Specify)	m, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,				
	the Hospital or in 24 hours after the Funeral Dir ipletely filled in edical Cert	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the base and mann	sis of examination and	deeth occurred at the tir	ppinion, death occurr	ed at the time, date	and place, and due	to the cause(s)				
D	within 2 To the comple	29b. Signature end title of certifie	To the state of th) mo	29c. Licens	_	29d.	Date signed (Month)	, Dey, Yeer)				
_	UF VG	30. Neme and eddress of person	who completed cause		Type, Print)	Deve Pl	Lank	m no	20706				
	State Registrar	31. Date filed (Month, Day, Year)		gistrer's Signature	Carles								

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death S. Timelof Death 1. Decedent's Name (First, Middle, Last) Month June Physician Earl Gregory Banks 2005 8:09A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George s

9. Birthplace (State or Foreign Country) Southern Maryland Hospital Clinton If Under 24 Hrs 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1⊠M 2□F Hours Director 52 July 30, 1952 Wash., 577-68-0175 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show traumatic event, the Madical Examiner must be notilied at 1X Yes 2 No Director Temple Hills Maryland Prince George's 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code death with 2213 Jameson St. 20748 or Itams 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Itam 27 Is marked other than "natural", or Ital 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: **Black** 2 If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working) life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Equipment/Construction Operator Private 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Earl Banks Shirley Ridgeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2213 Jameson St., Temple Hills, MD Gloria Graham Banks - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 ☐X remation 3 ☐ Removal from State Lee's Crematory 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2005 Clinton, MD 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASTROINTESTINEAL BLEEDING Physician /Medical Due to (or as a consequence of): CIRAHOSIS **Examiner** 1VEOZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner NEMIA burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 0 the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform certificate 1 Yes 2 🖾 No Division of Vital the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ဥ this in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After (Month, Day 1 Natural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D48158 samos samo J 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD #500 OXON OSIA 6192 OXON HILL SISOM 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 1 4 2005 Registrar

		For State Registrar	State of	f Maryla	nd / Depa	artment <i>rtificate</i>				Rag	ne 20	05	2142
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Funeral Director		Washington Ad 5. Social Security Number 6. S 579-68-4200 1			s. last birthday)	If Under 1 Months	Year	akoma If Under 24 F Hours M	in. 8. Da	te of Birth onth, Day, Y		9. Birthp Cour	omery lace (State or For
	ctor	Usual Residence of Decedent 10a. State 10b, County Maryland Prince	George'	10c. C	City, Town or Lo		er Ma	rlboro	Jar	1. 22,	1949		sh., DC Od. Inside City Lin 1 XYes 2 □
23a or 26 st be no	Funeral Director	10e. Street and Number 17102 Clai:				10f. Zip (ode	0772		10g	. Citizen of V Unit		tates
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ene. then "netur	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		-4or 5+)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use	Occupati done dui retired)	on ring most of v	working	16	b. Kind of Bu	ısiness/Ind	dustry
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nent of He int: If Item iry or othe		20a. Mathod of Disposition 1 ♣ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.		State	Place of Dispo cemetery, crer	natory or oth	er place)	v 6/	Date 77/20		. Location - Wash		
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ysicië	ical Examiner	Immediate Gause (Final disease 🛬 ndition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jesuss of high) that initiated events resulting in death) Last	C	or as a conse									Onset and Geat Well Year
ed by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ∐ Fet ant at time of	aldeiath 3∐	Ectopic preg					23d. Date Mor	of delive	ry Day Year
e e q	2	Part II. Other significant conditions o	ontributing to de	ath but not re	sulting in the ur	nderlying cau	se given	in Part I.	23				e cause of death
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Toth	ž	29b. Signature and title of certifier	0			29c. I	icense n				Date signed		, . ,
1		30. Name and address of person who	2011				65	361			6/11	105	20U -
(11)	ł		completed cause	of death (Ita	m 23a) (Tune	Print)							

State of Maryland / Department of Health and Mental Hygiene

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1			#90 Rd 4 Holl					Elkton		Cec			
	Funeral Director		5. Social Security Number 6. S 212-70-2451 Usuel Residence of Decedent	Sex 7. Age	(In yrs. last b	Yrs. If Und Month		If Under 24 H Hours Mi		rth ey, <i>Year)</i> 3/54	9. Birthp Coun E1kt	lace (State of try) On, M	or Foreign D
	yland		10a. Stete 10b. County		10c. City, To	wn or Location					11	0d. Inside C	
	ith the Marylan or 28a-f show	cto	MD Cecil		Elkto	on						YEJ Yes	2 □ No
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	ath w	ral	#90 Rd 4 Holl				921		(0 1/2 -	USA	ce - Americ	an Indian	
Maryland 21215-0036	filed within 72 hours after death with the Maryland hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be modified at	Completed by Funeral Director	11. Maritel Status N☐Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	ò	1 ☐ Yes	280 No	Specify:	(Specify Yes or Norto Rican, etc.)	Speci	ry: B	lack	
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ary	2 should be filed and Mental Hygi is marked other aumatic event,	-	19a. Informant's Name/Reletionship (Type, Print)	19	b. Mailing Addre	ss (Street	and Number or i	Rurel Route Numb	er, City or Town	, State, Zip	Code)	
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re,	# \$ £ £	Ī	20e. Method of Disposition		20b. Place cemet	of Disposition (A ery, cremetory o	ame of	ce)	Date	20c. Location	- City or To	wn, State	
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Baltimore,	permit. Pages Department of H Important: If its any Injury or of once.		21. Signature of Funeral Service Licer	nsee				ss of Facility Dupont		-Mulli	kin	F/H	
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	he att	Physician/I	Part II. Other significent conditions of	ontributing to death but	not resulting	in the underlying	ceuse giv	en in Pert I.	23b. Did	tobacco use co	ontribute to	the cause	of death?
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Division of Vital Records,	raquiras een sigu hould be	Completed by		performed?									findings to cause
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on o	Ing After une	atlon:	27. Manner of Death 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury M	28c. Injur Wor 1 □	yat k? Yes 2 □ No	28d. Describe	how injury occu	rred		
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	Within 2 To the compla	× ×	29b. Signature and title of certifier			2	9c. Licens	e number		29d. Date signe	ed (Month, L	Dey, Year)	
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	7		30. Name and address of person who 4701 Oale fou	completed cause of dec	eth (Item 23a)	(Type, Print)	Neu	vark	. De	19193			
	Sta	re	31. Dete filed (Month, Day, Year)	32. Registrer	's Sonature	parke		`		•			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** AMY BUNN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA If Under 1 Year PARK MONTGOMERY Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 □ M 2 🖾 F Director March 18 1930 North Carolina 578-46-7468 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show other traumatic event, the Madical Examiner must be nutilised at 1x Yes 2 No Director Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itema 23a 6302 Belfour Drive 20782 U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be liled within 72 hours after to Department of Health and Mental Hygiene. important: If tiem 27 is marked other than "natural", or ites any injury or other traumatic event, the Medical Exemina-☐ Yes 2 ☑ No Yes. Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 2 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef 11th Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jasper Hunter Frances Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bunn Jerry 6302 Belfour Drive Hyattsville, Maryland 20782 20b. Place of Disposition (Name of spmetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Red Hill Church Ceme 6/19/05 * 4 ☐ Donation 5 ☐ Other (Specify) Whitaker, North Carolina 21. Signature of Funeral Service Livensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death throscheratic Cardrovescular Desease Immediate Cause (Final Priysician disease or condition resulting in death) /Medical lue to (or as a consequence of) Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2. No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No ျှ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 621 30. The and andress of purion who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue Takoma Park, Maryland 20916 Stephen Smith M.D. 31. Date filed (Month, Day, Year) State JUN 1 5 2005 Registrar

		1 - For State Registrar		of Marylar	nd / Depa		t of H	ealth a	and M	ental Hy	•	0.5	211,25
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Exami		4a. Facility Name (If not institution		number)			· ·	Location of	of Death			nty of Death	
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Funeral Director		5. Social Security Number 212–14–6713	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. 92		If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Dec. 2	th ly, Year) , 1912		place (State or Foreign ntry) aryland
and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits
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28a	Funeral Director	10e. Street and Number									10g. Citizen o	f What Cou	ntry?
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date of delivery Month Day Year			
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VICAL ician: 'certifica ector, p	Be (25. Was case referred to medical examiner?						26. Place	e of Death	(Check only	one)		
Physic rthis ce	일	1 ☐ Yes 2 ☐ No			ER/Outpatie			4 Mu	ursing Hon	ne 5 🗆 Resi	dence 6 🗆 C	ther (Specif	fy)
tending Plate. Items After the funera		27. Manner of Death 1 □ Matural 5 □ Pendin 2 □ Accident investigned	ation	te of Injury onth, Day Year)	28b. Time of Injury	of 2	8c. Injury Work	vat k? Yes 2□		28d. Describe	how injury occ	urred	
tal or Atters atter de al Directe ed in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 280. Pla	ice of Injury - At h Ilding, etc. (Speci	nome, farm, st ify)	reet, factory	r, office		2	28f. Location (City or To		mber or Rura	al Route Number,
he Hospi n 24 hou he Funer pletely fill	edical	29a. Certifier 1 ☐ Certifyin (Check only 2 ☐ Medical one)	g Physician: To Exeminer: On the and m	the best of my kn basis of examin anner stated.	owledge, deat ation and/or in	th occurred evestigation	at the tim , in my op	ne, date an pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) and r date and place	manner as s e, and due to	tated. o the cause(s)
To t To t	Σ	29b. Signature and title of certific	1///					number	100		29d. Date sign		
in		1/600	uc		100	0.	02	64	99		6-1	13-0	5
MA		30. Name and address of person Ronald E.	who completed ca	tuse of death (Ite	m 23a) (Type,	Print)	Dr.	P.O. A	Box a	210 14	t.Ain	MI	0 21771
St Regist	ate rar	31. Date filed (Month, Day, Year)	3 2005	Registrar's Sign	ature								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:25 A **Physician** June Shirley Anna Carley /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 1749 West Regents Park Road Crofton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Apr. 30 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex .1926 **Funeral** Months 1 ☐ M 2 🛱 F Mississippi Yrs. 79 424-22-0231 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State f show ral, or items 23a or 28e-f show Examiner must be notified at 1 TYes 2 No Director Crofton MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21114 1749 West Regents Park Road Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

ent: If item 27 is marked other then "natural", or ite ury or other treumsite event, the Medical Exaction 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Defense Contractor Self employed 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Antoinette Anna Wein Charles Cooper Cress 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1749 West Recents Park Rd. Crofton, MD. 21114 S. Denise Carley / daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition tment of tent: If its jury or o 1 Burial 2 Cremation 3 Removal from State 07/05/2005 Arlington, VA. Arlington Nat. Cem. permit. Pag Department Importent: I any injury o *4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD. 9 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer set and Death Immediate Cause (Final disease or condition resulting in death) uterine cancer Years Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? ome Residence 6 Other (Specify)
28d. escribe how injury occurred Other: 4 \(\sum \) Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of De th Natural After 5 Pending 1 ☐ Yes 2 ☐ No investigation after death. Director: A 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in any original death. within 24 hours a To the Funerel C To the Hospital 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 052830 June 13, 2001 Elenine Weine, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanine Werner, mD 900 Bestgate Road #303 Annapolis MD 21401 31. Date filed (Month, Day, Year) JUN 1 4 2005 Registrar

		_ FOI	Department of Health and N Certificate of Death	Mental Hygiene			
		Decedent's Name (First, Middle, Last)		2. Date of Death COO Time Death			
Physicia		Kurt Patrick Chaney		June 08 2005 6:14 P			
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				
LXUITIII		Peninsula Regional Medical Center	Salisbury thday If Under 1 Year If Under 24 Hrs.	Wicomico			
Funeral Director		210 13 1104	Yrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Fore Country) Maryland			
w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Lim			
Maryla Ifed at	tor		sbury	1 ☐ Yes 2 X			
with the	Director	10e. Street and Number 30785 Hambrooks Court	10f. Zip Code 21804	10g. Citizen of What Country? USA			
be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene do ther than "natural", or items 23a or 28a-f show event, it a Modical Examinar must be notified at	Funerai	11. Marital Status 1 □ Never Married 2 Married I □ Never Married	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 28 No Specify:	pecify Yes or No- Prican, etc.) 14. Race - American Indian, Black, White, etc.			
atural', c	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a.	Decedent's Usual Occupation	Specify: white			
vithin 72 ne. han "ng e Medit	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired) ter Technician	Electric			
Hygie Hygie ther I		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Sumame)			
of Should be filed within hand Mental Hygiene. 7 Is marked other than "traumatic event, It a Max	To Be	George Chaney		ale Kendall			
t and 2 should t Health and Mer item 27 Is marke other traumatic			. Mailing Address (Street and Number or Rui 0785 Hambrooks Court	ral Route Number, City or Town, State, Zip Code)			
Health tem 27 other tr	and a second	20a Method of Disposition 20b. Place of	Disposition (Name of	Date 20c. Location - City or Town, State			
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pennic. Tages I and 2 Department of Health a Important: If item 27 II any injury or other tra		21 Squature of Funeral Service Licensee	22. Name and Address of Facility Holloway Funeral Ho	ome Professional Association			
		23a. Part1. Enter the disease, or complications that caused the death. Do		Salisbury, MD 21804 or respiratory arrest. Approximate			
nysician /Medical xaminer		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	njuries	Interval Between Onset and Death			
itte tak requires that the death continuate be executed at the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen					
ned by the attending prince as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery Month Day Year			
signed b	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.				
ate has been signaled bage 2 should b	Completed			Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No			
	0	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)			
d is	To B	1 X Yes 2 No Hospital: 1 □ Inpatient 2 X R/Ou		ome 5 Residence 6 Other (Specify)			
After I		1 □Natural 5 □ Pending (Month, Day Year)	Time of 28c. Injury at work? 1 ☐ Yes 2 N No	28d. Describe how injury occurred that collide operator of motorcycle that collide operator vehicle			
i gitt	Certification;	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 50 East Bo			
within 24 hours a To the Funeral I completely filled	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated					
within To the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
0		I hig his mis	OCME	June 09, 2005			
100		30. Name and address of person who completed cause of death (Item 23a)	111 Penn Street	Baltimore, Maryland 21201			
-	ite	31. Date filed (Month, Day) 921 3 2005 32. Agistrar's Signature	Search .				

			For Amend Ite	State of Mem 1 per Dr.	aryland ,G857	,07, <u>2</u>	rtment of H	ealth and I Death		giene	0 =	21120
	Ohusisi		1. Decedent's Name (First, Middle	(e, Last) Raymo	nd	Chambe	rlain		2. Date of Dea	ath Day	Year	9. Time of Death
	Physicia /Medic	al	RAYMEND	LCHAMBE		 	45 City Town or	Location of Decil	June	4c. County	005	9',35 AM
	Examin	er	4a. Facility Name (If not institution	n, give street and number	Medir	1/ nte	4b. City, Town, or	Balt	more	4c. County	OI DOZ(II	
	Funeral Director		5. Social Security Number 216–28–4985		ge (In yrs. Ia 73	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		1931	9. Birthpla Count Mary	ace (State or Foreign land
	pur *		Usual Residence of Decedent 10a, State 10b, County	,	10c. City	, Town or Lo	cation				10	d. Inside City Limits
	the Marylar 28a-f show	JO.		omico		alisbu						1X Yes 2 □ No
	r 28a-	Irect	10e. Street and Number	жеее		211000	10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
	23a o	ral D	301 Brewingtor				2180			USA		
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. It marked other than "natural", or Itams 23e or 28e-f show inher traumatic avant, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	? No	1	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 1 No	n, Mexican, Puerl	pecify Yes or No to Rican, etc.)		e - America k, White, e :: Wh	
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d 21	filed v Hygie other t		12 17. Father's Name (First, Middle,			rasu			me (First, Middle,			
Maryland	uld be Aental rked c	To Be	George F. Cha	amberlain			- Application of the state of t	Matilo	la Litzau	1		
lary	2 short		19a. Informant's Name/Relations			1	g Address (Street a					Code)
	1 and 3 Health tam 27		Ruth Chamberla 20a. Method of Disposition	iin/wife	20b. Pt	ace of Dispo	Brewington Street Stree		Salisbur Date	20c. Location		vn, State
nor	Pages Nent of I nt: If its ry or o		1 இBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		CE	emetery, cren	natory or other place Cemetery		6/05	Salisb	200	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If itam any injury or othe		21. Signature of Funered Service		ESP	Ho Ho	Name and Address FOLLOWAY FOLLOWAY FOLLOWAY FOLLOWAY H	s of Facility uneral H	lome Prof	essiona	l Ass	ociation
	F-1		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cause t only one cause on each	d the death line.	. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
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.O. Box	he death the atter shed for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				te of deliver	y Day Year
0	es tha	by	Part II. Other significant condit	ions contributing to death	but not resu	ulting in the u	nderlying cause give	en in Part I.		obacco use cont	ribute to the	e cause of death?
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alF	Th ate pag	e Col	25. Was case referred to medical	21				OC Disease of Da	1 Yes	No		No
		O B	examiner?	Hospital:	ient 2 🗆 I	ER/Outpatier	t 3 DOA Othe	200	ath <i>(Check only c</i> Home 5 ☐ Resid		er (Specify)
ivision of		T :uc	27. Manner of Death	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe I	now injury occur	red	
ا S S	Attending r death. actor: After by the fune	catle		tigation	ations. As he	60		Yes 2 □ No	29f Location (Street and Numb	ner or Pumi	Poute Number
Ž.∑	or At after of Diraci	Certification;		minor 280. Place of I	atc. (Specify	me, rarm, str	eet, factory, office		City or To		or or Aurar	House Number,
	To the Hospital or Attend within 24 hours after death To tha Funaral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medice	ing Physician: To the bes I Examiner: On the basis and manner:	of examinat	wledge, deatl tion and/or in	occurred at the time vestigation, in my op	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and ma date and place,	inner as sta and due to	ated. the cause(s)
	To the Hos within 24 ho To tha Fun completely	Me	29b. Signature and title of certific			1-	29c. License	number 35 W/5140		29d. Date signe		
	40		Shan	Wasen	-, r	10				June,	11, 3	2005
-	30		30. Name and address of person Shameel Wasa	an, 22 S. Gr	eene	St, B	altimore	, MD ZI	201			
	Sta Regist		31 Date filed (Month Day Year	1 5 2005 32. Rs	trar's Signa	ture A	Sperte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Time by Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Steinberg Werner June 10. 2005 1520 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SALISBURY WICOMICO ANCHORAGE NURSING & REHAB CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 216-74-4681 6/2/1940 New Jersey Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ?7 ie marked other than "natural", or Itams 23a or 28a-f ehow traumatic event, the Madical Exandrac must be natitied at 1 ☐ Yes 2 🖾 No Director Maryland Somerset Princess Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With 33140 W. Post Office Road 21853 USA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. nent of Health and Menial Hygiene. ant: If Item 27 ie marked other than "natural", or Ita 1 □ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2X No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none 0 none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Oliver Nelson Carey Dorothy Lewis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33140 W. Post Office Rd, Princess Anne, MD 21853 Georgia Williams/niece f Health is litem 27 i other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Depertment of H
Importent: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6/13/05 Salisbury Crematory Salisbury, MD 21. Signatur of Funeral Service Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oncycar ASWI resulting in death) /Medical Due to (or as a consequence of) **Examiner** DYSPHAGIA 6 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): attending physicien for use as the buria Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 5 Other (specify) signed by the a d be detached t ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No has 1 ☐ Yes 2 ☐ No certificate 1 Yes To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE BK 2005 DR. 45HA NATESAN. 0057359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1415. S. DIVISION

JUN 1 5 2005

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Division of Vital

ORIGINAL

SAUSBURY

distrar's Signature

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			For State	State of Man	yland / D		Health and I	Mental Hygi	ene	0:10:
			Registrar 1. Decedent's Name (First, Middle, La:	st)		ooramoato o	Douth	2. Date of Death		8. Nime of Beath
	Physici		Mildred Ann Dave					Month JUNE	Day Year	4: 30 A.M
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town	, or Location of Deatl	h	4c. County of Deat	h
			Worth Arundel	MOSPITAL	l		BURNIE		Anne AR	
	Funeral Director		220-36-2587	5ex 7. Age (//	fin yrs. last birti	fiday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Jun. 20	9. Birti Co	nplace (State or Foreign untry) MD
	and w		Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town	or Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be reditied at	ctor	MD Anne A	rundel		Arno				1 ☐ Yes 2 ☑ No
	with th	Dire	10e. Street and Number	n Dood		10f. Zip Code		10	g. Citizen of What Co	
+	eath v	eral	31 Jones Station	12. Was Decedent Eve	ar in U.S.		21012 f Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
Saven pak 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	31 117 3.3.	If Yes, specify Co	f Hispanic Origin? (S uban, Mexican, Puerl lo <i>Specity:</i>	o Rican, etc.)	Black, White	
2011	72 ho	Completed	15. Decedent's E	ducation ade completed)	16a.	Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	supation ne during most of wo	rking	6b. Kind of Business/	Industry
200	ithin Je.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)						
	iled w tygier her th	Col	12 17. Father's Name (First, Middle, Last,	1		School Bus		me (First, Middle, M	Transport	ation
anc ,	d be findal h	Be C	Richard Chaney				Agnes		,	
<u> </u>	shoute nd Me mark matie	P	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stre			City or Town, State, 2	Tip Code)
Na Ma	nd 2 saith ar 27 is		Bobbie Eugene Da	avenport/Hus	band :	31 Jones S	tation Roa	ad, Arnol	d, MD 210	12
Sre,	ss 1 a of Hear Item		20a. Method of Disposition		cemeter	Disposition (Name of y, crematory or other p	olace) Jun	e 16.	20c. Location - City or	
\mathcal{M} : \mathcal	Page Iment c		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	fy)	Metro	Crematory		2005	Baltimore,	
Balt	permit. Depart Import any in		21. Signatura Funeral Service Lice	Man		Barranco 495 Gov.	& Sons, P ritchie H	.A. Sever wy, Sever	na Park Fu na Park, M	neral Home D 21146
•	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. URINARI Due to (or as a c	y TR	AGT INF		c or respiratory arre	st.	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box (To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ ¶o 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	ncy		23d. Date of del Month	ivery Day Year		
<u>8</u>	res that the igned by be detact	by Pt	Part II. Other significant conditions	contributing to death but r	not resulting in	the underlying cause	given in Part I.		acco use contribute to	the cause of death?
oro	v requires been sign should be	eted						-		
Bec	The law sate has t page 2 s	Compl						24a. Was ar autops perform 1 Yes 2	ed? death?	topsy findings available completion of cause of 2 No
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		_		ath (Check only one		
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on	ding th. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	rear) li	njury V	Vork? □Yes 2□No			
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	ie Hospit 124 hours ie Funere letely fille	dical (29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medicel Exa	hysicien: To the best of eximiner: On the basis of example and manner state	xamination an	, death occurred at the d/or investigation, in m	e time, date and place y opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. Lice	ense number	25	d. Date signed (Mont	h, Day, Year)
				cassahin		. D. DO	05597	3	FLINE 11,	2005
			30. Name and address of person who Zeleice Des.	se 11500	sth (Item 23a)	(Type. Print) 1 and Hi	11 WOY	S1/ Ve> S	pring, ~	10 26904
	St	ate	31. Date filed (Month, Day, Year)	2005 32. Registrar's	a digitature	And .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0205AM 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Salisbury

Vear If Under 24 Hrs.

Min.

Months

Physician /Medical Examiner For State Registrar

oastal

10a State

MT

11. Marital Status

Director

Funeral

00

5. Social Security Number

220-32-8009

10e. Street and Number

Usual Residence of Decedent

Hospice

10b County

1607 EMERSON AVENUE

1 Never Married 2 X Married

at the

1 XM 2 ☐ F

6. Sex

WICOMICO

7. Age (In yrs. last birthday)

71

12. Was Decedent Ever in U.S. Armed Forces?

1-

Funeral Director the Maryland 28a-f show with ō or Itams 23a "natural",

other traumatic event, it e Medical Examiner must be notified at filed within 72 hours after Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other trainments.

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Physician /Medical **Examiner**

burial-transit certificate be executed attending physician as the ISB S detached certificate has

Hospital or Attending Physician: 24 hours after death. Funaral Diractor: After this certified within 24 hours a To the Funeral L To tha

1 XYes 2 ff ff Yes, Give Year or Dates: 1955 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be LEE S. DISHAROON 19a. Informant's Name/Relationship (Type, Print) GLORIA DISHAROON - SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Society License 23a. Pari1. Enter the disease, or complications the shock, or heart failure. List only one cause on Immediate Cause (Final Metastall disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Completed Be 25. Was case referred to medical examiner? Hospital: 1 🗌 Yes 2 ER/Outpatient 3 DOA ည Marher of Death Date of Injury (Month, Day Year) 28c. Inju 28b. Time of 5 Pending Natural investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of fnjury · At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No SALISBURY 10g. Citizen of What Country? 10f. Zip Code 21801 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No Specify: Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry CITY OF SALISBURY HOUSING INSPECTOR 18. Mother's Name (First, Middle, Maiden Surname) SARAH HANNAH ANDERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 EMERSON AVENUE, SALISBURY, MARYLAND 21801 20c. Location - City or Town, State CREMATORY OF DELMARVA 06-13-2005 DELMAR, DELAWARE 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Dept Concer

8. Date of Birth (Month, Day, Year 06-03-1934

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an

23d. Date of delivery

Day

Year

Month

Wicomico

Birthplace (State or Foreign Country)

SALISBURY, MD.

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No 1 Yes

26. Place of De	ath (Check only one)
her: 4 Nursing	Home 5 Residence 6 Other (Specify)
ryat ork?]Yes 2 ☐No	28d. Describe how injury occurred
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

126278 6-10-05 PO. BOX 1733 Solsby, MD 21862 026278

eath (Item 23a) (Type, Print) and address of person who completed cause

JUN 1 3 2005

DHMH 17 Rev 1/2001

State

Registrar

1[

			For State	State of Ma	-	epartment Certificate					
	a		Registrar 1. Decedent's Name (First, Middle, L	ast)		001111100110	0. 000		Date of Death	2005	Time of Death 3
	Physici /Medic		Mary	Ann Dorse	0				Month D	lay Year	-19:30 PM
	Examin		4a. Facility Name (If not institution, g.	1 -		4b. City, To	(/	ation of Death	4	c. County of Deal	th
			5. Social Security Number 6.		Courty	day) If Under 1	Vear Itil		Date of Righ	Cecil	theless (State of Faraire
П	Funeral Director		173-32-2801	1 □ M 2 □ 1 7. Age	o (In yrs. last þ irth 65 Y			ours Min.	Date of Birth (Month, Day, Yea arch 21	, 1940 CC	thplace (State or Foreign buntry) PA
			Usual Residence of Decedent				1	1 11	21011 21	7 1 5 10	
	show	_	10a. State 10b. County		10c. City, Town						10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	Ba-f	Director	MD Cecil		Perry	ville			10- (Citizen of What Co	
	with t	Ö	10e. Street and Number	1.1		10f. Zip C	2190				ouridy?
	after death with the Marylan or Items 23a or 28a-f show if the Fruilles A	Funerai	345 Broad S	12. Was Decedent I	Ever in U.S.	13. Was Decede		ic Origin? (Specif exican, Puerto Ric		U . S . A .	
9	after or Item	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ 4 If Yes, Give	fo	If Yes, specif		exican, Puerto Hid ecify:	an, etc.)	Black, Whit	
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-1 show Jisel Exa: Il act must be multifud at	d by	3 ₩idowed 4 Divorced	Year or Dates:						Specify: Wh	
15-(n 72 hours "natural", edicul Exe	Completed	15. Decedent's (Specify only highest g	Education rade completed)		Decedent's Usual Give kind of work life. DO NOT use	done during	most of working	16b.	Kind of Business/	/Industry
12	within lene. than "	duc	Elementary/Secondary (0-12)	College (1-4or 5	+}	Housev				Househ	old
	be filed within 72 hours a ital Hygiene. Ind other than "natural", o event, I'm Medicul Exer	0	17. Father's Name (First, Middle, Las			nouse.		Mother's Name (F	irst, Middle, Maide		
/lar	should be nd Mental marked c	To B	Robert S.	Homler				Esther	Schenc	K	
Maryland	2 SE SE SE SE SE SE SE SE SE SE SE SE SE		19a. Informant's Name/Relationship	_					loute Number, City	or Town, State, 2	Zip Code)
	ss 1 and of Health item 27 other to		R.Gerald Dors 20a. Method of Disposition	o/Son		Libby Disposition (Name		, Elkto	on, MD	21921 Location - City or	Town State
Jor	Pages nent of H int: If ite		1 Burial 2 Cremation 3		cemetery	, crematory or oth	er place)				
Baltimore,	그 된 본 글 .		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic 		Schen	22. Name and			18,2005	Howar	a, PA
Ba	permi Depa Impo any it	. 1	> Elward	Mc Keows	L	_			neral H	ome	
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence o		1	1			4 1
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	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	20010 (01 00	a concequences	',					
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9		Med	IF FEMALE:	00- 14	-6					1	
Вох	ath certif attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic prec				23d. Date of del Month	ivery Day Year
P.O.		Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown	time or death	J _ Calor (spec	y/				
	law requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant conditions				use given in l	Part I.	23e. Did tobacco	use contribute to	the cause of death?
ırds	w require been sig should b		Puripleal	Vescular	disca	10			1 🗆 Yes	2) 54 0 3□Pr	obably 4 Unknown
Records,	e law re has be ge 2 sho	Completed	End Stage	Vescular rend	clisea	16			24a. Was an autopsy	prior to o	utopsy findings available completion of cause of
= E	Th ate pag	Con	,						performed?	death?	2 □ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	Place of Death (C		A (70)	
ō	Phys or this oral di): To	1 ☐ Yes 2, No 27. Manner of Death	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	y 28b. Ti		c. Injury at Work?		5 Residence d. Describe how in		city)
ion	Attending F r death. ector: After by the funer	atio	1 Datural 5 Pending 2 Accident investigati	(Month, Day on	/ Year) In	jury M	Work? 1 ☐ Yes	2 🗆 No			
Division	or Atte	ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			m, street, factory,	office	28f	Location (Street and City or Town, Sta		ural Route Number,
Ω	urs aff	O									
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	dical	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best on the basis of aminer: On the basis of and manner sta	examination and	death occurred at or investigation, in	the time, da n my opinion	ate and place, and n, death occurred	at the time, date a	s) and manner as nd place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c.	License num	nber	29d. D	ate signed (Monti	h, Day, Year)
	. , , , ,		Alfred	Viv.no	MO	D	005	5190	Ju	me 10	2005
	2		30. Name and address of person wh	7	eath (Item 23a) (T			. / 5	UST E	()	2
				rve MD	Univa ar's Signature	Hospit	9/ 1	06 Boc	VIT E	1 Kiton	MX) (1981
	Sta Registr		31. Date filed (Month, Day, Year)	ken a b	a a signature	e i					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SHAN E. EYSTER State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2005 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Shan Eugene Eyster 14, JUNE 2005 0313 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 20, 1971 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**%** M 2□ F 441-66-3736 34 Oklahoma Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County irat", or items 23a or 28e-f show Exercities towal be notified at MD Washington Hagerstown 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 1827 Abbey Lane U.S.A. Funera Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 If Yes, Give Specify: White 1 ☐ Never Married 2 ☐ Married 2 **⋈** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 MDivorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) plumbing oe filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) tradesman business 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ss 1 and 2 should be fi of Health and Mental H item 27 is marked of Delbert R. Eyster Lois M.Horst ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Coventry Ct. Mount Vernon, OH 43050 19a. Informant's Name/Relationship (Type, Print) Delbert Eyster 20b. Place of Disposition (Name of cemetery, crematory or other place) June 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H importent: If ite any injury or ott once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, MD 2005 Smithsburg Crematory ^ 4 □ Donation 5 □ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final) 21. Signatura Funeral Server cens Immediate Cause (Final Priysician muticle injuries resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 cai Physician/Medi as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d, Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day detached for 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Ď 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2□ No Yes 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28d. Describe how injury eccurred 28a. Date of Injury (Month, Day) 27. Manner of Death 28b. Time of of or Attending Parties death. Certification: Cos which 5 Pending investigation 1 Natural Seed object 1 ☐ Yes 2 X No 2 Accident truck 12 3 Suicide 6 Could not be Location (Street and Number or Rural R. Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide SKeet To the Hospitel of within 24 hours at To the Funerei D Hospitel Washington Counts 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the oedse(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 14, 2005 JUNE OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11 Penn Street Baltimore, Maryland 21201

15H-12

State Registrar

32. Registrar's Signature

JET 05-040	_			Type or Pri	nt in Bla	ack ind	lelible Ink.	Ensure A	II Copies		•	e .	
David	Alan El	.in	For State Registrar	State of Ma	aryland		rtment of Ha tificate of L		vientai Hy	_	e 2005	= 0	11.25
			Hegistrar Decedent's Name (First, Middle, La	nst)	-		imodio oi E	Journ	2. Date of D	eath		3	3. Time of Death
	Physici /Medi		David Alan Eli	ne					June	11	ау Ye L 200		:40_P
	Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or	Location of Deat		4	c. County of D		
			Route 140 and Bau	igher Road	e (in yrs. last	t hiethelau)	Finksbur If Under 1 Year	Westing Westing	ninster 8. Date of Bi	()	Carroll		- /State or Foreign
	Funeral Director			10 M 2□F	45	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di Nov 2	3 19	959	Country)	e (State or Foreign PA
	/land		10a. State 10b. County		10c. City, T	own or Lo	ation					10d.	Inside City Limits
	ith the Marylan or 28a-f show e notified at	ctor	MD Carro	11	F	inksh	ourg						1 ☐ Yes 2x No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 1921 Fawn Way				10f. Zip Code 210	48		10g. C	USA	Country	?
	r deal	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. V	as Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	14. Race - A Black, V	merican hite, etc.	
21215-0036	ours afte rrai', or It	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Tes 2 1	No .		Yes 2 No	Specify:				Whit	
15-(n 72 h "natu edica	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	1	6a. Deced	ent's Usual Occupa kind of work done d O NOT use retired)	ition uring most of wor	king		Kind of Busine er Park		try
212	iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5	5+)		Foreman			Pav	<i>y</i> ing		
פֿע	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Las	1)				18. Mother's Nan	ne (First, Middle	, Maide	n Sumame)		
Maryland	Menta	Tof	Charles B. Elin	e, Sr				Joan M					
Mar	2 sho		19a. Informant's Name/Relationship				Address (Street a				or Town, Stat 21048	e, <i>Zip C</i> o	de)
	1 and Health em 27	1	Joan Miller/moth	er	20b. Place	e of Dispos	Fawn Way		burg, M		ocation - City	or Town,	State
ρ	ages ant of it: If it y or o		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Special				atory or other place		/2005		neytown		
Baltimore,	mit. F partme sorter / injur		21. Signatury of Ineral Service Lie		Grac		Name and Address		-			-	
ä	Depa Impo any ir	A B	1 K. Set.	netto	7	41	.2 Washin	eral Hon orton Roa	e and C d West	nape mins	ster. M	1D 2	21157
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each li	the death. [ne.	Do not ente	r the mode of dying	, such as cardiad	or respiratory a	arrest,	,	Ap	proximate erval Between aset and Death
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	ecuted and I-transit	camine	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
90,	oe exe cian a urial-l	ய	resulting in death) Last	Due to (or as	a consequen	ce of):							
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Box 6	eath certificate be ex attending physician for use as the burial	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of	delivery	
œ.	Physicien: The law requires that the death certificate be ex this certificate has been signed by the attending physician : ral director, page 2 should be detached for use as the burial	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnancy Other (specify)				Month	Da	y Year
P.O.	that the de ed by the detached	Phys	9 Unknown						00 D:11				
	ires thai signed b	by	Part II. Other significant conditions	contributing to death b	ut not resultin	ng in the un	derlying cause give	n in Part I.			/	Probably	ause of death? 4 □Unknown
Sor	w requir been si should	etec							24a. Was		_		findings available
Rec	The law cate has page 2 s	Completed							auto	psy ormed?	prior	to comple	etion of cause of
Division of Vital Records,	ilcien: Th certificate rector, pag	e)	25. Was case referred to medical					26. Place of Dea	th (Check only o	2 🗆 No		es 2□	1 NO
>	ding Physicien: n. After this certific funeral director,	To B	examiner? 1 XYes 2 □ No	Hospital: 1 Inpatie	nt 2□ER	/Outpatient	3 ☐ DOA Othe	r: 4 🗆 Nursing H	ome 5 Resi	dence	6XOther (S	pecity)S	cene
0	ding Pi I. After tl funera	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	Year)	b. Time of Injury	28c. Injury Work	at ?	28d. Describe				0.44.40.40
isio	deatl deatl ctor: / the	cat	2 Accident investigation 3 Suicide 6 Could not to	O Class of Init		16291		es 2 No	28f. Location (MEAR BYCKS
Div	of or Attendated after death Director:	Certification:	4 Homicide determined	building, etc	c. (Specify)		et, ractory, office		City or Ton	wn, Stat	e)	,	
	To the Hospitei or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune	edical C	(Check only 2 Medical Exa	hysician: To the best	of my knowled examination	dge, death	occurred at the time	e, date and place inion, death occu	and due to the	cause(s	and manner	as stated	d.
	o the ithin 2 o the omplet	Med	29b. Signature and title of certifier	and manner sta	it⊌0.		29c. License	number		29d. Da	ate signed (Mo	onth, Day	, Year)
	1		1 Mayor	no (Mal	Q W	v)	OCME			Trans	10	2001	5
	M70		30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type, F	rint) 111 D-	m C+		June		200	S:
			111119 12 10 (1)	17 ICORE	, C		TIT Pen	n Street		illore	e, Mary	Tand	21201
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 3		ar's Signature		porte						

) _					23a&27 pe	aryland r me G	7 Depa 845 e	irtment of H	lealth Death	1		Reg. No	00	5_	21436
	Physici	an	Decedent's Name		•					2	. Date of De Month	ath Da	y Y	'ear	3. Time of Death
	/Medio			Rayno1do							June 1		2005		2319 p M
F	Examir	ıer	4a. Fecility Name (If	not institution, giv	e street and number,)		4b. City, Town, or	r Location	of Death		4c	. County of	Death	
7-			9412 Che	ltenham A	venue		16146 1 1	Clinton	lá Hada	0411=0			rince		
2	Funeral		5. Social Security No. 578-94-89		ex 7. Aq M∑M 2□F	ge (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours	Min.	Date of Bir (Month, Da	y, Year)		Cour	
79	Director		Usual Residence of	701		42	115.			No.	ov. 11	, 1	962 1	Wasl	nington, DC
4 1	land bw		10a. State	10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	Mary f sh	ō	Maryland	Prince	George	Clint	on								1⊠Yes 2 No
	the 288	Director	10e. Street and Nun					10f, Zip Code				10a. Cit	tizen of Wha	at Cour	ntry?
	3a or	Ī	9412 Che	1 + h /				207	35				ted S		
	death ms 2	era	11. Marital Status	rtelliam r	12. Was Decedent	Ever in U.S.	13. \	Vas Decedent of H f Yes, specify Cuba		rigin? (Specif	y Yes or No		14. Race -		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Inportant: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations must be notified at 900ce.	by Funeral	1 ☐ Never Marrie 3 ☐ Widowed	ed 2□ Married 4 🖾 Divorced	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			i Yes, specify Cuba I □ Yes 2 🙀 No	n, Mexica Specify		can, etc.)		Black, Specify:		_{etc.} 31ack
ŏ	2 ho	Completed	(0.17)	15. Decedent's Ed	ducation		16a. Deced	lent's Usual Occup	ation			16b. K	ind of Busin	ness/Inc	dustry
215	hin 7	ple	Elementary/Secon	fy onfy highest gra	College (1-4or	5+)	life. L	kind of work done o OO NOT use retired	during mo f)	st of working					
21	od will	Ω	12				Ent	repreneu	r			Pr	ivate		
p	be file ntal Hy od oth event	Be (17. Father's Name (First, Middle, Last)					18. Moth	er's Name (F	First, Middle,	Maiden	Sumame)		
<u> a</u>	should b nd Ment marked umatice	10	Charles	McLeese					0:	rphas	Freema	an			
a	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Men		19a. Informant's Na		• • • • • • • • • • • • • • • • • • • •			g Address (Street a							Code)
	and and n 27 n 27		LenNard 1		Brother			Cheltenh		ve, CI	inton,	, MD	207	35	
ore	of Horitan		20a. Method of Disp		Removal from State	20b. Plac	ce of Dispo: netery, cren	sition (Name of natory or other plac	e)	Date	9	20c. Lo	ocation - Cit	ty or To	wn, State
E.	Pag ment ant: ury c			5 Other (Specif		Harm	ony M	emorial 1	Park	6/25/	05	Sui	tland	, Ma	aryland
Baltimore,	permit. Departr Importu any Inji		21. Signature of Fur	neral Service Licer	angar	10108	A]	Name and Address Lexander 38 Marlb	S of Facil	Pope F	uneral Forest	L Hon	mes le. M	D 2	20747
			23a. Part1. Enter th	e disease, or com	plications that cause one cause on each li	the death									Approximate
	Physician		Immediate Cause (I	Final	Cardiom	_									Interval Between Onset and Death
	/Medical		resulting in death)	-	Due to (or as		nce of):							-	
	Examiner														
-		ner	Sequentially list con any leading to im- cause. Enter Under	nditions, mediata	b. Due to (or as	a consuluer	nce of				-				
	rtificate be executed g physician and as the burial-transit	Examiner	that initiated events	njury	С.										
Ö	e exe		resulting in death) L	ast	Due to (or as	a consequer	nce of):								
68760,	ate be nysici he bu	Medicai			d										
	150 B	Med	IF FEMALE:		111111111111111111111111111111111111111							-			
.O. Box	The law requires that the death centate has been signed by the attendin	Physician/N	23b. Was decedent in the past 12 in Yes 2 9 Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)					23d. Date o Month		ry Day Year
۵	s that	by P	Part II. Other signifi	cant conditions c	ontributing to death b	ut not resulti	ng in the un	derlying cause give	n in Part	l.	23e. Did to	obacco u	use contribu	ite to th	e cause of death?
rds	quires n sign										1 🗆 Y	/es 2	□No 3[Prob	ably 4 Dunknown
Records,	w requ	Completed									24a. Was	an	24b. Wer	re autor	osy findings available
Re	The lav	E C										rmed?	prio dea	r to cor th?	npletion of cause of
Vital		a l	25. Was case referr	ed to medical					OC Plac	e of Death (C		2 No	THE.	Yes	2 No
5	Physician: this certifica ral director, I	OB	examiner?	Ì	Hospital:	ent 2 EF	R/Outnation	3□ DOA Othe	200	ursing Home			6 Y ther (Cassil	a magazinasa mana k
of	ig Phy ter thi	-	27. Manner of Death		28a. Date of Inju (Month, Da		Bb. Time of	28c. Injury	at		I. Describe h			Эреспу	At Scene
Division	들도조크	atlo	1 ANatural 2 Accident	5 Pending investigation		y rear)	Injury	Work M 1 □ 1	ດ? Yes 2. [No					
Vis	or Attend after death Director: / in by the f	ific	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of in	ury - At home	e, farm, stre	et, factory, office		28f.				or Rura	Route Number,
	alor A s after il Dire	Certification:	4 CITOMICIO		building, et	c. (Specify)					City or Tow	m, State	")		
	To the Hospital or within 24 hours at To the Funeral D completely filled in	edical (29a. Certifier (Check only one)	1 Certifying Ph 2 XMedical Exam	ysician: To the best niner: On the basis o and manner st	f examination	edge, death n and/or inv	occurred at the time estigation, in my op	e, date ar sinion, dea	nd place, and ath occurred	due to the dat the time, d	cause(s) date and	and manne I place, and	er as st due to	ated. the cause(s)
	To the within 2 To the Complex	Me	29b. Signature and	#7				29c. License	number			29d. Dat	te signed (A	Aonth, I	Day, Year)
) la	melle	ce Al	-		OCM	E			Jun	e 20,	200)5
	c D			ss of person who	completed cause of c	leath (Item 2:	3a) (Type, F		· · ·		D - 1 · ·	-			
-	4			LLAH				111 Pen	n Sti	reet .	baltin	iore	, Mary	/Lar	IG 21201
	Sta Registr	2.5	31. Date filed (Monti	n, Day, Year) N 2 2 200		ar's Signatur	6	do							

			1 - For State Registrar	State of	Maryland		artmen rtificat			and M	lental Hyg	iene •9. No 20	n E	2110
6	Physic	ian	1. Decedent's Name (First, Middle, Las					0. 1	Joann		2. Date of Deat	h	~ .	3. Time of Death
5	/Medi	cal	Mary Beatric 4a. Facility Name (If not institution, give				4h Cihi	Town or	Location	4.0	June /	21 ^{Day} 200		8:23P M
	Exami	ner	Frederick Memo		-	1		der	Location o	of Death		4c. County		ı.le
	Funeral	Г	Social Security Number 6. Se	x 7.	Age (In yrs. las			1 Year Days	If Under a		8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		214-46-5066 Usual Residence of Decedent	□M 2□XF	96	Yrs.	IVIOTILIS	Days	Hours	Min.	8. Date of Birth Feb. 12.	,"°1′909	Mar	y Land
	/land		10a. State 10b. County			Town or Lo							1	0d. Inside City Limits
	a-f sh	ctor	Maryland Frederic	k	Jeff	ferso	n							1 ☐ Yes 2 No
	th with the 23e or 28 ust be not	al Director	10e. Street and Number 2503 Lander Roa	d			10f. Zip 217.	Code 55			10	U.S.A	/hat Cour	ntry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "netural", or Items 23e or 28e-1 show other traumetic event, the Medical Exatininal per rollined at	by Funeral	11. Marital Status 1 Never Married 2 Married XXWidowed 4 Divorced	12. Was Decede Armed Force 1 ☐ Yes X2X If Yes, Give Year or Date	s? ⊒No		Was Deced f Yes, spec 1 ☐ Yes		spanic Origin, Mexican, Specify:	jin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	Blac	- Americ k, White, Whi	
5-0	72 hc 'netu	Completed	15. Decedent's Edi (Specify only highest grad	ication le completed)		16a. Deced	dent's Usua	l Occupat	tion	of worki	na .	6b. Kind of Bu	siness/Inc	dustry
121	within ene. then	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of wor DO NOT us Homema		goo.	o, works	, ig	Own H	omo	
d 2	filed Hygie other ent, II		17. Father's Name (First, Middle, Last)			l	TOMEM		18. Mother	r's Name	(First, Middle, M			
Maryland 21215-0036	2 should be filed with and Mental Hygiene. Is marked other ther eumetic event, the M	To Be	James Nuse	0.1.0					M	inni	e Fry			
	1 and 2 sl Health and tem 27 ls n		19a. Informani's Name/Relationship (T) Mary Ann Patricia Blan	k, Daughte		_			ocks	Road	J Route Number. Jeffei	city or Town, s	State, Zip D 21	755
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1	lemoval from Sta	. cem	etery, cren	sition (Nam natory or ot uthera	her place	etery		24, 2005	oc. Location - (Jeffe		
Balt	permit. Departr Imports eny inju		21. Signature of Funeral Service Licens	Hrol	M00255	24	Keene 06 Eas	y ^{Address} st Ch	r Bas nurch	ford	PA Fune , Freder	eral Ho	me D 217	701
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caus	ed the death. I	Do not ente	or the mode	of dying,	such as c	ardiac o	r respiratory arre	st,		Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition	SM		MEZ			Ruc				450	Onset and Death 3 AAYS
	/Medical Examiner		resulting in death)		as a consequen			A_A	14				-	1
		er	Sequentially list conditions, if any, leading to immediate		RA ABI		r/C	/\\	NES	LON	7-4			YEATES
V	cuted Id ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o	e exerian ar		resulting in death) Last	Due to (or a	is a consequen	ce of):								
8760,	cate be executed physician and the burial-transit	dicai		1										
9 X	death certific attending pl	/Me	IF FEMALE:	3c. If yes, outcom	ne of pregnancy	,								
. Box	death certifi e attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant	2 ☐Fetal de at time of death	ath 3 🗌	Ectopic pre Other (spe	gnancy cify)				23d. Date Mont		y Day Year
0.	that the deatl	hys	9 □ Unknowň	9∐ Unknown										
Vital Records,	sign sign d be	by	Part II. Other significant conditions cor	tributing to death	but not resultin	g in the un	derlying car	use given	in Part I.				oute to the	cause of death?
900	has been ge 2 should	ompleted		_							24a. Was an	24b. W	ere autop	sy findings available
r =	ate pag	Con									autopsy performe	d? de	or to com ath?] Yes 2	pletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:						f Death	(Check only one)			
ō	hys his I di	: To	1 Yes 2 No	28a. Date of In		Outpatient b. Time of			4 LJ Nurs		e 5 Residen			
0	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	M	c. Injury a Work? 1 □ Ye	s 2∐No		3d. Describe how	injury occurred	1	
	or Attence after death Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	njury - At home, etc. (Specify)	, farm, stree	et, factory,				3f. Location (Stre	et and Number	or Rural	Route Number,
ַ בֿ	itel or irs afte ral Dir led in	Cer		1							City or Town,			
:	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	ician: To the bes er: On the basis and manner s	UI OXAIIIIIIIIIIIIIIII	dge, death and/or inve	occurred at estigation, in	the time, n my opin	date and ion, death	place, ar occurred	nd due to the cau d at the time, date	se(s) and manr a and place, an	ner as stat d due to t	ted. he cause(s)
	To t		29b. Signature and title of certifier	111	.4	, A	29c.	License n	umber			. Date signed (
				Illa	in t	เก		Dl	667	5				2005
	2		30. Name and address of person who co	Monre	R,	a) (Type, R	rint) Puw	501	CIZ,	1	10 2			
H	Sta Registra	te ar	31. Date filed (Month, Day, Year)	05 32. Pois	trar's Signature	1	Pun	3.0						

			1- State Unpend Iter		land/Dep ne G845 _e	artment of F 7-14-05 t	lealth and N Beath	/lental H	ygiene Reg. No n	15 211 20
	Physic	ian	Decedent's Name (First, Middle, I Charlene		nmore			2. Date of D Month	Day Day	Year 3. Time of Olah
	/Medi Exami		4a. Facility Name (If not institution, g		more	4b. City. Town, or	Location of Death	June	16 2 4c. County	2005 1002 M
			Prince George's	Hospital Cen	ter		erly			nce George's
000	Funeral Director		5. Social Security Number 577-72-2395 Usual Residence of Decedent	Sex 7. Age (In 53	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D April	28,1952	Birthplace (State or Foreign Country) DC
	yland now		10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
	the Marylar 28a-f show notified at	ctor	DC	Wa	shingto	n				XX Yes 2 □ No
	with the	Dire	10e. Street and Number 3618 Minnesota A	2 E		10f. Zip Code			10g. Citizen of V	Vhat Country?
	ms 23e	erai	11. Marital Status	12. Was Decedent Ever	n U.S. 13.	20019 Was Decedent of Hi	spanic Origin? (Sp		USA	e - American Indian,
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Item 27 Is marked other than "naturel", or items 23e or 28e-f show other treumatic event, the Madical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	Armed Forces?		If Yes, specify Cuba 1 ☐ Yes XXNo	Specify:	Rican, etc.)	Blac	k, White, etc.
5-0	72 hc "natur	etec	15. Decedent's (Specify only highest of	Education rade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation	ina	16b. Kind of Bu	
2121	within ene. than	Completed	Elementary/Secondary (0-12)	Coilege (1-4or 5+)		DO NOT use retired, il Sales)	9	-	
d 2	other	Be Co	17. Father's Name (First, Middle, Last	st)	Reta.	ii saies	18. Mother's Name	e (First, Middle	Pvt Inc., Maiden Sumam	
ylar	should be nd Menta marked umatic ev	To B	Charles B Hoke				Louise	Tillma	n	
, Maryland	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other than other treumatic event, Item		19a. Informant's Name/Relationship Ruth Holland — S	(Type, Print) Sister	19b. Mailir 8600	ng Address (Street a Mike Shap	nd Number or Rura Diro Dr #	807 Cl	per, City or Town, . inton, M	State, Zip Code) 1 20735
Baltimore,	ges 1 t of He If iten or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3		b. Place of Dispo cemetery, crer	sition (Name of natory or other place	9)	Date	20c. Location -	City or Town, State
Ē	permit. Pages : Department of F Important: If ite any injury or ot	,	' 4 ☐ Donation 5 ☐ Other (Spec 21. Sign Fire of Furreral/Service Lie	ify) R	esurrect		6-24-	05	Clinton	, Md 20735
Ba	permit. Departi Import any inj		23a Part 1. Enter the disease, or do shock, or heart failure. List and	EMSON	6	Name and Addres 503 Old E	Bel Branch Av	l Funer e. Temp	al Home, le Hills	PA s, Md 20748
8760,	Physician /Medical Examiner the pnual-transit the pnual-transit	ai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	rearing	ny per cens		ITTOVASCO	
P.O. Box 687	the death certifical by the attending phy ached for use as th	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of	etal death 3 [Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year
	w requires that been signed b should be det	þ	Part II, Other significant conditions	contributing to death but not	resulting in the un	derlying cause give	n in Part I.			bute to the cause of death?
Division of Vital Records,	The ate his page	e Completed	25. Was case referred to medical					1X Yes	osy pr ormed? de 2□No 1[ere autopsy findings available for to completion of cause of eath?
Ϋ́	8 s	To B	examiner? 1 XYes 2 No	Hospital: 1 Inpatient 2	☑ER/Outpatient	045	26. Place of Death 4 □ Nursing Hon		dence 6 Other	(Specify)
sion o	fter free free free free free free free		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury Work?	at 2		now injury occurre	
Divis		Certification:	3 Suicide 6 Could not to determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre	et, factory, office	2	28f. Location (3 City or Tox	Street and Number	r or Rural Route Number,
	To the Hospitel or within 24 hours after to the Funeral Dir completely filled in	edicai	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☑ Medical Exa	nysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	occurred at the time estigation, in my opi	, date and place, a nion, death occurre	nd due to the d at the time,	cause(s) and mani date and place, an	ner as stated. and due to the cause(s)
	To the within To the comple		29b. Signature and title of certifier	and mainer stated.		29c. License				(Month, Day, Year)
)		ĺ	· Carol H	Manind		OCME			June, 1	18, 2005
R			30. Name and address of person who	completed cause of death (It	tem 23a) (Type, F	rint) 111 Penn	Street	Baltim	ore. Marv	vland 21201
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Sig	nature				,	,
	Registra	ar	JUN 2 2 200	Marie	Come	51				

Physician

/Medical

Examiner

Funeral

Director

the Maryland

To Be Completed by Funeral Director

	Pleas	e Type or Pri	nt in Black li	ndelible Ink. Ensure A	II Copies A	re Leaible.	
For Stata Registrar			aryland / Dep	partment of Health and I	Mental Hygie	_	21439
Decedent's Name	e (First, Middle,	Last)			2. Date of Death		3. Time of Death
WILLI	IAM F.	GRIFFIN			JUNE J	Day Year 18, 2005	10:00PM
4a. Facility Name (I	f not institution,	give street and number,		4b. City, Town, or Location of Death		4c. County of Dea	
VA MARY	LAND H	EALTH CAF	E SYSTEM	PERRY POINT		CECIL	
5. Social Security N	lumber 6	5. Sex 7. A	ge (In yrs. last birthda		8. Date of Birth (Month, Day, Yo	ear) 9. Bir	thplace (State or Foreign
218-07-5		1 X M 2□F	91 Yrs.	1000	7/4/1913		yland
Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town or	Location			10d. Inside City Limits
MD	Harfo	ord		ngdon			1 □ Yes 2 20 No
10e. Street and Nur	mber	·		10f. Zip Code	10g	. Citizen of What Co	ountry?
3301	Emmor	ton Road		21009			USA
11. Marital Status		12. Was Decedent	Ever in U.S. 13	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
	ied 2□ Marrie	d 1 √2 Yes 2 □	No	1 ☐ Yes 2 ☑ No Specify:			
3X Widowed		Year or Dates:					hite
(Spec	15. Decedent's cify only highest	Education grade completed)	(Gir	edent's Usual Occupation re kind of work done during most of wor . DO NOT use retired)	king 16	b. Kind of Business	/Industry
Elementary/Seco	ondary (0-12)	College (1-4or	54)	Equipment Operator		Construc	tion
17. Father's Name	(First, Middle, L	ast) Griffin			ne (First, Middle, Ma		
Joseph				Siglalo Tano Abore			Zip Code)
		111/3011		Sickle Lane, Abero		21001	Tour State
		3 □Removal from State ecify)	camatani ci	ematory or other place)		c.Location-City or prest Hi	
21. Signature of Fu	un P.	houlis	d the death. Do not s	22. Name and Address of Facility Harkins Funeral Home, Inter the mode of dying, such as cardiac			Approximate
shock, or hea Immediate Cause disease or condition	artfailure. Listo (Final on	nly one cause on each	ine.	AL INFARCTION			Interval Between Onset and Death UNKNOWN
resulting in death)		Due to (or a	s a consequence of):				
Sequentially list co	onditions,		PENSION				UNKNOWN
Sequentially list co l any, ladding to in cause. Enter Unde Cause (Disease or	nmediate erlying		ra consequence of): nerc Merri 1	ישווכ שאטה דד			************
that initiated events resulting in death)	s	C	res mell: s a consequence of):	TUS TYPE II			UNKNOWN
-		545 10 (01 a					
	,	d					
IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □ No		2 Fetal death	B⊟Ectopic pregnancy S⊟ Other (specify)		23d. Date of de Month	livery Day Year
Part II. Other signi	ficant condition	ns contributing to death	but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
		RUCTIVE P			1 ☐ Yes	2□No 3□P	robably 4 Unknown
-					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
25. Was case refe	rred to medical			26. Place of Dea	th (Check only one)	3	
examiner?	No	Hospital: 1X Inpai	ient 2 ☐ ER/Outpat	ient 3 DOA Dther: 4 Nursing H	lome 5 Residence	ce 6 □Other (Spe	ecify)
27. Manner of Dea 1 Natural 2 Accident	th 5 Pending investigs		ury 28b. Time ay Year) Injur	of 28c. injury at	28d. Describe how		
3 Suicide 4 Homicide	6 Could no	ot be 28e. Place of I	njury - At home, farm, etc. (Specify)		28f. Location (Stree City or Town,		ural Route Number,

Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit

Physician /Medical

within 24 hours atter death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached.

10 State

Registra

29a. Certifier (Check only one)

29b. Signature and title of o Much 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ung

20390

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

JUNE 21, 2005

CHARLES HOESCH, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902
31. Date filed (Month, Day, Year)
32. Begistrar's Signature

JUN 2 8 2005

05-3886 B.K.S DONALD A. GRAVES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11.	D A. GN		For State Registrar	State of Ma	aryland / [tment of H		Mental Hy		2005	21440
ı	Physici		1. Decedent's Name (First, Middle, I Donald A.	ast) Graves					2. Date of De Month JUNE	Day	y Year 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g SOUTHERN MARYLAN			4	4b. City, Town, or CLINTON			4c.	County of Death RINCE GE	
	Funeral Director		5. Social Security Number 6. 056-44-7780	Sex 7. Age	e (In yrs. last bii 54		If Under 1 Year Months Days	if Under 24 Hr Hours Mir		th ay, Year)	9. Birthp	place (State or Foreign http)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Loca	tion					Od. Inside City Limits
	Maryla	tor	Md. P.G.		Templ							1 XYes 2 No
	or 288	Jirec	10e. Street and Number		<u></u>		10f. Zip Code			10g. Cit	izen of What Cour	ntry?
	s 23s	rail	5913 Fisher R			1.2.11	2074				ted Sta	
36	d within 72 hours after death with the Maryland jene. Ir than "natural", or Items 23a or 28a-1 show It a Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:			is Decedent of His es, specify Cubar Yes 212 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.))- 	14. Race - Americ Black, White,	etc.
5-0036	72 hou natura	eted	15. Decedent's (Specify only highest of	Education		. Deceder	nt's Usual Occupa	tion	arkina	16b. Ki	Blac ind of Business/In	
121	filed within Hygiene. othar than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. DC	NOT use retired)			D×	izzata	
מ	Hyg Hyg ant,	e Co	17. Father's Name (First, Middle, La			mput			ame (First, Middle		ivate	
lan/	ad Des	To Be	Robert J. Gra	aves				Thel	ma Wrig	ht		
Maryland	nd 2 shuith and 27 is m		19a. Informant's Name/Relationship Jaree L. Grave		er $\overset{19b}{4}$	Mailing 002 emp1	Address (Street a 23rd Pl e Hill:	nd Number or F KWY # S Md .	Rural Route Numb 11 20748	er, City o	r Town, State, Zip	Code)
altimore,	Pages 1 a nent of Hea int: If itam iry or othe		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3	Removal from State	20b. Place o cemete	f Disposit ry, crema	ion (Name of tory or other place)	Date		ocation - City or To	
<u>=</u>	permit. Page Department of Important: If any injury or once.		*4 ☐ Donation 5 ☐ Other (Special Service Licenses)	pify)	Rive		e Crem				erdale,	
Ra	perm Depa Impo any i		Mance S	AWALO							dwards	F.H. Md.20746
	15		23a. art. Enter the disease, or co	mplications that caused by one cause on each lin	the death. Do						,	Approximate Interval Between
	Physician		Immuniate Cause (Final disease or condition resulting in death)	a Hypert	ensive	1.16	Lucscle	votic a	ardiovas	alo	u Discose	Onset and Death
	/Medical Examiner			Du lo (or as	a consequence	of):						
-	cuted nd rransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	of):						
58/60,	ficate be executed g physician and is the burial-transit	edical Ex	resulting in death) Last	Due to (or as	a consequence	of):						
_			IF FEMALE:	23c. If yes, outcome	of pregnancy						22d Date of deliver	
O. Box	at the death certif by the attending tached for use at	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗍 Fetal déath		ctopic pregnancy Other (specify)				23d. Date of delive Month	Day Year
rds, P.	as the	by	Part II. Other significant conditions	contributing to death bu	ut not resulting i	n the und	erlying cause give	n in Part I.		obacco u Yes 2[ne cause of death?
Vital Records,	The taw require cate has been si page 2 should I	Completed									prior to cor death?	psy findings available apletion of cause of
ıtal	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					_	ath (Check only		7 73	20.110
	ling Phys	tion; To	Yes 2 No 27. Manner of Death Natural 5 Pending Notice investigat	28a. Date of Injur (Month, Day		Itpatient Time of Injury	28c. Injury Work	4 Nursing	Home 5 Resi 28d. Describe		6 XOther (Specify y occurred	AT SCENE
Division of	al or Attences after death	Certification;	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be as Blood of Init	ury - At home, fa c. (Specify)	arm, stree			28f. Location (City or To		d Number or Rura)	l Route Number,
	ne Hospital or n 24 hours afte na Funeral Dli pletely filled in	edicai C	29a. Certifier (Check only one) 1 Certifying I	Physician: To the best of aminer: On the basis of and manner sta	examination an	e, death o	ccurred at the time stigation, in my op	e, date and place inion, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	To the within 2. To the I complete	Me	29b. Signature and title of certifier	. 1			29c. License				e signed (Month,	
	00		Plande Ha	llanu	d		OCI	TE.		JUI	NE 7, 200	JO
3/	e la		30. Name and address of person wh	o completed cause of d	eath (Item 23a)	(Type, Pr	int) 1111 Penn	Street	Baltim	ore,	Maryland	1 21201
	Sta	- 1	31. Date filed (Month, Day, Year) JUN 1 5 20		ar's Signature	1.	·					
	Registr	ar	A TON TO SO	· District	A 4	1 11/2 1	V					

			1 - For State Registrar	State of Ma	•	partment of lertificate of				iene	A ==	
	Physicia	an	1. Decedent's Name (First, Middle, Las	1	HAU	50 B		2	. Date of Deat Month	th ZU	Year	Tree de Edath
	/Medic		4a. Facility Name (If not institution, give		1/1/4	4b. City, Town,	or Location o	of Death	6		y of Death	11:30 A M
	Examin	er	Anne Arundel Medi	·	•		polis	OI DOMIN		Anne		de1
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthd	ay) If Under 1 Year	If Under	24 Hrs. 8	. Date of Birth			
	Director		065-20-6502	X M 2□F	80 Yrs	Months Days	Hours	Min. J	Month, Day, une 27	, Year) , 1924	New	place (State or Foreign ntry) York
	D.		Usual Residence of Decedent									
	arylar show	_	10a, State 10b. County		10c. City, Town o							10d. Inside City Limits 1 X Yes 2 □ No
	Ba-f	cto	MD Anne Arun	del	Cr	ofton						
	with ti	급	10e. Street and Number	1 D 1		10f. Zip Code	11/		1	0g. Citizen of		ntry?
	s 23	era	21312 Davidsonvil	12. Was Decedent E	voc in U.S.		114	ining (Consi	fu Van as Na	USA		can Indian,
	72 hours after death with the Maryland naturel', or Itams 23a or 28a-f show alsal Examiner must be notified at	Funeral Director	11. Marital Status 1 □ Never Married 2 🛣 Married	Armed Forces?	0	 Was Decedent of If Yes, specify Cub 	oan, Mexicar	n, Puerto Ri	can, etc.)		ick, White,	
936	urs af	by	3 Widowed 4 Divorced	1 ∰Yes 2 ☐ N If Yes, Give Year or Dates:	WW II	1 □ Yes 2 🗓 No	Specify:			Speci	fy: W	hite
P	2 ho	ted	15. Decedent's Ed		16a. De	cedent's Usual Occu	pation			16b. Kind of E		
21	thin 7	nple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5-	+) lif	e. DO NOT use retire	ed)					
7	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 Transportation Supervisor											bution
nd	17. Father's Name (First, Middle, Last) 18. Mother's Name (F										me)	
S												•
Maryland 21215-0036										21012	i, State, ∠ij	Code)
										20c. Location	- City or T	own, State
Baltimore,	ages ant of rt: If it		1 ABurial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify		1	crematory or other pla		06/16				
Ħ	artme ortan Injur		21. Signature of Funeral Service Licens	~	rib. vet	erans Ceme 22. Name and Addr	ecery ess of Facilit	ty Boo	11 Fun	orel U	main,	MD.
ä	Depa Impo any It		- C Ruga	Vousel	2	6512 NW C			Bowie		2071	5
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do not					<u> </u>		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition			LANCER						Onset and Death
	/Medical		resulting in death)	d	consequence of):	////,			-		-	1 / WA
П	Examiner		Sequentially list conditions,	b								
	sit ad	luel	cause. Enter Underlying Cause (Disease or injury	Dua to (or as a	Lechsequence of):							
_	xecuti and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of);							
8760,	cate be executed obysician and the burial-transit	dlcal E										
687	fficate p phys	edlo		d								
Вох	death certifica e attending ph id for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		0.05-4				23d. Da	ate of deliv	ery
-		sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	;y			М	onth	Day Year
P.0	that the deed by the detached	hys	9 Unknown									
	Se ng eq	by	Part II. Other significant conditions co	entributing to death bu	t not resulting in th	e underlying cause g	ven in Part I.	•	A			he cause of death?
ord	w requir been si should	ted	57/						1000	as 2□No	3 Prot	oably 4 Unknown
lec	aw S S	Completed							24a. Was a autops	sy .	prior to co	ppsy findings available impletion of cause of
E H	Th ate	Co	H	YPERTENS	ION				perform 1 Yes 2	ned? 2 X No	death? 1 ☐ Yes	2 No
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			han		Check only on			1
of	Phys rthis ral dii	To To	1 Yes 2 No 27. Manner of Death	1 Inpatier 28a. Date of Injur		e of 28c inv	ırv at		5 ☐ Reside			(y)
on	iding Ph th. After thi funeral	tlor	1 X Natural 5 ☐ Pending investigation	(Month, Day	Year) Inju	ry Wo	ink?]Yes 2.⊟l			,.,	-	
Division of Vital Records	or Attanding after death. Diractor: After in by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm,	street, factory, office		28			ber or Run	al Route Number,
á	s after s after al Dira	Certification;	4 Hornicae	building, etc	. (Зреспу)				City or Town	n, State)		
	To the Hospital or Attanwithin 24 hours after deat To the Funaral Diractor:	edical (29a. Certifier 1 Y Certifying Phy (Check only 2 Medical Exam	rsician: To the best of iner: On the basis of	f my knowledge, d	eath occurred at the t	ime, date an	nd place, and	d due to the ca	ause(s) and m	anner as s	stated.
	To the H within 24 To the F complete		one)	and manner sta	ted.							
	With Con	Σ	29b. Signature and title of certifier	St. 1	11 ~	29c. Licen		- / /-		9d. Date signe		
	00(3)11	1	Marvey 1-	reinge	-2.03		Do 5			76/12		
(RUI	9	30. Name and add ass of par on who of	ompleted cause of de	eath (Item 23a) (Ty	pe, Print)	31	SH	707/	SIDE	7 0	7611
	Sta	te	31. Date filed (Nonth, Day, Year)			2111	10 y	510	e //	0	per U	UT
	Registr	3	JUN 1 4 2005	Glove	r's Signature	ule).						

HUDDCK, FRANCES DOB 7/28/37 173-30-1906 Baltimore Maryland 21215-0036

			1 - For State Registrar	State of Marylan		artment of F tificate of		Mental Hy	giene Reg. N20	05	21	442
ľ	Physicia		Decedent's Name (First, Middle, Last) FRANCIS	J.	HUDO	CK		2. Date of Dea Month JUNE	ith Day	Yeer 005	3. Tim	o of Death
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)	поро	4b. City, Town, o			4c. County	of Death		230
-		, it	ATLANTIC GENERAL HO 5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	BERI	IN If Under 24 H	'S 9 Date of Birt		RCEST		4
l.	Funeral Director		173-30-1906	1 2□F 67	Yrs.	Months Days	Hours Mi		1937			ANIA
	ow out	į	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	0d. Inside	e City Limits
	death with the Maryland ms 23s or 28a-f show	ctor	DELAWARE SUSSEX	S	ELBYVI	LLE					1 🗆 Y	′es 2∑No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Cour	itry?	
	s 23£		205 WEST STONEY		C 40.3	199		(0	US			
30	d within 72 hours after death with the Marylan jiene. rithan "naturat", or Itams 23c or 28a-1 show Ite Marical Examination in the	by Funerai	11. Marital Status 12 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1960•		was Decedent of F f Yes, specify Cub 1 ☐ Yes 2X No		(Specify Yes or No- erto Rican, etc.)	Specify	e - Americ ck, White, ': WHI	etc.	1,
-00030	2 hour		15. Decedent's Educa	tion		dent's Usual Occup	pation		16b. Kind of Bu	WILL		
213	within 72 ene. than "na	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	DO NOT use retire	d)				,	
7	filed wi Hygien other th	Con	12 17. Father's Name (First, Middle, Last)		CONS	TRUCTION		ame (First, Middle.	ELECTI		TILI	TIES
and	d la la la la la la la la la la la la la	To Be		UDOCK				NICA	GIMMI	/		
ary	d 2 should th and Men ?7 is marke traumatic	1	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	ng Address (Street	and Number or I	Rural Route Numbe			Code)	
e, Mai	s 1 and 2 f Health is itam 27 i		JOAN L. HUDOCK/WIFE		-		NEY RUN,	SELBYVII				
<u> </u>	e ° ≠ 5		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rer		Place of Dispo cemetery, crer MANCHE	sition (Name of natory or other place		Date	20c. Location -	,		
Baitimor	permit. Page: Department o Important: If any injury or		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Si atur Funeral Service Lic See	UNI	ON CEM	ETERY 2. Name and Addre		6/05	MANCHES	STER,	PA	
ğ	Depril Impo		healy Wit in		HA	STINGS F	UNERAL H	IOME, SELI		DE.	199	75
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Saurentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	uence of):	Lung	Guc		est,		Onset a	Between nd Death
68/60,	tificate be executed ig physician and as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consec	uence of):							
O. Box 6	requires that the death certific seen signed by the attending p hould be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown	ıl death 3 [Ectopic pregnancy	y			te of delive	ery Day	Year
rds, F	tuires that n signed b ıld be deta	by	Part II. Other significant conditions contri	buting to death but not res	sulting in the u	nderlying cause giv	en in Part I.		bacco use cont es 2 □ No	nbute to th		of death?
Hecord	has by	Completed						24a. Was autop perfor	sv	Were auto prior to condeath?	npletion	ngs available of cause of
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					eath (Check only o				
01	y S	To.	1 Yes 2 No Hos	28a. Date of Injury	ER/Outpatier		4 🗀 Nursing	Home 5 ☐ Resid			1)	
		tion	1 Alatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	yat rk? Yes 2□No	28d. Describe ii	ow injury occurs	90		
DIVISION	of or Attandi after death. Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str (y)	reet, factory, office		28f. Location (S City or Tow		er or Rura	l Route N	lumber,
	Hospite 4 hours Funarat ely filler	edicai C	29a. Certifying Physic (Check only one)	ien: To the best of my knor: On the basis of examinating and manner stated.	owledge, death ation and/or in	n occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the courred at the time, of	cause(s) and ma date and place,	inner as st and due to	ated.	se(s)
	To tha within 2 To tha complet	Me	29b. Signature and the of certifier	00	7	29c. Licens	se number	7	29d. Date signe	d (Month)	Day, Yea	r)
	01 7		III X dian	uli	للمد	Da	016 (111	6//	U	/>	
,	1,793		30. Numer and address of person who com	pleted cause of death (Iter	п 23а) (Туре,	Print) /20	to Te	Cent M	De	1990	14	
[Sta Registi		31. Date filed (Month, Day, Year) JUN. 1 4 200	32. Figistrar's Signa	ature /	harts ,						

			For State Registrar		State of N		d / Depa		t of H	ealth a	and M	-	/gien	2005	211.1.3
40,	64		Decedent's Name (First	, Middle, La	st)				0, 2			2. Date of D	eath		3. Time of Death
	Physici /Medic		James	Ηi	11							June	8,	2005	10:03PM
	Examir		4a. Facility Name (If not in	stitution, giv	e street and numbe	er)		4b. City,	Town, or	Location of	of Death		—i—	c. County of Death	
			Southern 1	Maryl	and Hos	pital		Cl	int	on			I	Prince G	eorges
	Funeral		5. Social Security Number		Sex 7.7	Age (In yrs. la		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year	9. Birthp	lace (State or Foreign
L	Director		420-16-172 Usual Residence of Dece	4	2		85 Yrs.					March			ΚŸ
	land ow			County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Many Ff sh	to	Md. I	G.			Templ	e Hi	lls						1⊠Yes 2□No
	or 28g	irec	10e. Street and Number					10f. Zip					10g. C	itizen of What Cour	ntry?
	23a (23a (23a (23a (23a (23a (23a (23a (ai	3420 Ricke	y Av	enue			20	748				Uni	ted Sta	tes
	tems	Funeral Director	11. Marital Status		12. Was Deceder Armed Force	s?	S. 13. V	Vas Deced f Yes, spec	ent of His	spanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race - Americ Black, White,	
36	s afte	by Fu	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ D		1 X Yes 2 [If Yes, Give			I□Yes 2		Specify:					
9	d within 72 hours after death with the Maryland Jiene. r than "natural", or tems 23a or 28a-f show the M-cifcal Examinative toolified at	edit		ecedent's E	Year or Dates	s:	16a. Deced	lent's Usua	I Occupa	tion			165	Specify: Blac Kind of Business/Inc	!K
215	nin 72 n "n	Completed	(Specify only Elementary/Secondary	/ highest gr	ade completed)		(Give life. L	kind of wor OO NOT us	k done di e retired)	uring most	t of workir	ng	100.	Killid of Dusifiessyllin	dustry
212	d within giene. er than "	mo;	6	0-12)	College (1-4c	N 3+)	Bus	Driv	er				Pı	rivate	
pu	be filed y ital Hygie id other i	Be	17. Father's Name (First,)					18. Mothe	r's Name	(First, Middle	, Maide	n Sumame)	
yla	should be ind Mental marked o umatic eve	2	Oscar H	ill						Jose	phir	ne Gi	cave	es	
Maryland 21215-0036	2 a s a		19a. Informant's Name/Re				19b. Mailin 3420	g Address	(Street a	nd Numbe Ave	nue	l Route Numb	er, City	or Town, State, Zip	Code)
	1 and Health Im 27		Josephine 20a. Method of Disposition		/wire	20h BI	Temp	le A	III	s, M		20748 ate	00-1		
Baltimore,	0 0		1 XBurial 2 ☐ Crer	nation 3		re :	ace of Dispo- emetery, cren							ocation - City or To	
Ħ	그 든 합 글		' 4 □ Donation 5 □ C			Res	urrec						Cli	nton, M	d.
Ba	permi Depa Impo any ir		Done	101	Selin	4100								dwards F	.н. Md.20746
	¥		23a. Part1. Enter the dise	ase, or com	plications that caus	ed the death								iiciand,	Approximate
	Physician		Mock, or heart failurediate Cause (Final	e. List only											Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	-	a.	as a sinsequ									
Ē	Examiner		Sequentially list condition		Ron	al D	pilu/	9							
	P = ==	iner	Sequentially list condition if any, leading to immedia cause. Enter Underlying	te /	Due to (or a	as a consequ	ence of):								
	ecute and -trans	Examine	that initiated events resulting in death) Last		C										
8760,	cate be executed oblysician and the burial-transit				Due 10 (01 8	as a consequ	ence or):								
687	A Y B	edicat			d										
Box (death certifica attending ph d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregr	ant	23c. If yes, outcom									23d. Date of delive	DV.
M	death e atte d for	iciai	in the past 12 month		1□Live birth 4□Pregnant	at time of de		Ectopic pre Other (spe	gnancy ecify)						Day Year
P.0	t the by th ache	Physician/M	9 Unknown		9□ Unknown										
		by F	Part II. Other significant of			but not resu	tting in the ur	derlying ca	use give	n in Part I.		23e. Did	tobacco	use contribute to th	e cause of death?
prd	w requires been sign should be		Prostate									10	Yes 2	No 3☐Prob	ably 4 □Unknown
Vital Records,	law as b	Completed	ARTICOS	کان کرھار	ic heat	Disee	ne					24a. Was	psy	24b. Were autor	osy findings available
H	Th ate pag	Con										perfe 1 ☐ Yes	ormed? 2 XN	death?	2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to examiner?	medical	Hospital:							Check onl	-		
ō	Phys this ral dii	. To	1 Yes 2 No 27. Manner of Death		1 Inpa 28a. Date of Ir		PVOutpatient 28b. Time of		A Care	4 Nur				6 □Other (Specify)
on	tending Ph leath. tor: After th the funeral	tion	- mail	Pending investigation	(Month, L	Day Year)	Injury	M	Sc. Injury Work?	es 2□N		8d. Describe	now inju	ily occurred	
Division		fica	3 Suicide 6 🗆	Could not be	e 28e. Place of I	Injury - At hor	me, farm, stre		-		-	8f. Location (Street a	nd Number or Rural	Route Number.
Ö	al or A s after il Dire	Certification;	4 Homicide	401011111104	building,	etc. (Specify))					City or To	wn, Stat	e)	
	e Hospital 24 hours a e Funeral I etely filled	edicai (29a. Certifier 1 C	ertifying Ph	nysician: To the bes	st of my know	viedge, death	occurred a	t the time	, date and	d place, a	nd due to the	cause(s	s) and manner as sta d place, and due to	ated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medi	Unity .		and manner	stated.	On and or my				III OCCUITO	d at the time,			
	To To	~	29b. Signature and title of	certitier	(License					ite signed (Month, L	
,	000		- Weste	- 1	completed	Edward for	02-) CT	2-1-1	234	206			JU	me 9, 20	>1
	UFU		30. Name and address of William	T.	TANNER W	death (Item	23a) (Type, I	-rint) LUI -	of to a	n Ro	nd'	Fut a	JASK	Jington, 1	monyland
	Sta Registr	_	31. Date filed (Month, Day	_	S2. Regis	strar's Signati	Sport.							ř	•

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			1 - State Registrar			ertificate o		R	eg. NO 11	5 21444
	Physici	an	Decedent's Name (First, Middle, Last) Clarence Junior Hand	37				2. Date of Dear Month	Day	ear / 7 - M
	/Medic Examin		4a. Facility Name (If not institution, give street and			4b. City, Town	, or Location of Dea	Dune	4c. County of	
		٠.	Peninsula legional	Nedica	1 Center	- Sal	1:5bord		Wico	Nico
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □	7. Age (I.	In yrs. last birthda Yrs.	y) If Under 1 Yes Months Day			Year)	D. Birthplace (State or Foreign Country) VA.
	pu »		Usual Residence of Decedent 10a. State 10b. County	14	Oc. City, Town or	Location				1404 1-11-01-11-1
	death with the Maryland ms 23e or 28a-f show ground be notified at	or			Mardela					10d. Inside City Limits 1 ☐ Yes 2 XNo
	r 28a-	Director	Md. Wicomico 10e. Street and Number		Haruera	10f. Zip Code)	1	0g. Citizen of Wh	at Country?
	th with		810 Mill Bridge Road			218	37		USA	
	be filed within 72 hours after death with the Marylan dal Hygiene. Id all Hygiene. Id other than "neturel", or flems 23e or 28a-f show onther than "neturel", or flems 23e or 28a-f show event, it is Macilcal Examinational to notified at	Funeral	Arme	Decedent Eve d Forces? 'es 2 2 No	er in U.S. 13	B. Was Decedent o If Yes, specify Co	f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
0 0 0 0	ours af	by	If Yes	G, Give or Dates:		1□Yes 211 N	lo Specify:		Specify:	White
2	72 hc	leted	15. Decedent's Education (Specify only highest grade comple	ted)	16a. Dec (G/h	cedent's Usual Occ ve kind of work dor	cupation ne during most of wo ired)	orking	16b. Kind of Busi	ness/Industry
7 1 7	e filed within 72 hours after at Hygiene. I other than "neturel", or Ite vent, I's: Madical Exercities	Completed	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)		. bo noruse reli chanic	rea)		Truck	S
2	be filed stat Hyg od other event,	Be C	17. Father's Name (First, Middle, Last)					ime (First, Middle, I		
yland	2 should be and Mental is marked eumetic ev	To	John Taylor Handy					Tain Handy	, 	
Mar			19a. Informant's Name/Relationship (Type, Print, Cecil C. Handy, Broth				et and Number or A			ate, Zip Code)
a)	os 1 and of Health item 27 other to		20a. Method of Disposition		20b. Place of Dis	Dalewood position (Name of		Date Va	 24033 20c. Location - C 	ty or Town, State
E	Pages nent of int: If its iry or o		1 ☐ Burial 2 【Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State		ematory or other p	marva 6-1	4-05	Delmar	, D.e
Baltimor	permit. Pages Department of Importent: If it eny injury or c		21. Signature of Funeral Service Licensee	/			dress of Facility Ineral Hon			
	40300		23a. Part 1 Enter the disease, or complications to	hat caused the	e death Do not e		ove St. I			Approximate
<u>;</u> [Physician		23a. Part & Enter the disease, or complications to shock, or heart failure. List only the cause Immediate Cause (Final disease or condition							Interval Between
	/Medical Examiner		resulting in death)	e to (or as a c	onsequence of):		ardiovas		<i>U</i> /- <i>C V</i>	
į.		er			onsequence of):	Eail W	ve-		_	
	oe executed cian and ourial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	cir	1031	's OF	KIVER.			
ρΩ,	be executed ician and burial-transit		resulting in death) Last Du	e to (or as a co	onsequence of):		,			
780	certificate Iding physi	edlca	d							
XOD	eath certificate be attending physici for use as the bu	M/us	230. Was decedent pregnant	, outcome of p		B⊟Ectopic pregnar	ıcv		23d. Date	,
	ne death the atter hed for u	Physiclan/M	1 Ves 2 No. 4 P	regnant at tim Inknown		Other (specify)			Month	n Day Year
ŗ	that the led by th detache		Part II. Other significant conditions contributing	to death but n	not resulting in the	underlying cause	given in Part I.	23e. Did tol	Dacco use contrib	ute to the cause of death?
cords	w requires that the de been signed by the should be detached	ed by						1 □ Ye	9s 2 □ No 3	Probably 4 Donknown
ă)	a SCA	ompleted						24a. Was a autops	n 24b. We	ore autopsy findings available
	Th ate pag	Соп						perform	ned? dea	or to completion of cause of ath? Yes 242 No
VII a	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	5/		_ ()ther	ath (Check only on		
ō		on: To	27. Manner of Death 28a. D	ate of Injury	2 ER/Outpati	of 28c. In	4 Nuising i	Home 5 ☐ Reside	ence 6 Other ow injury occurred	· · · · · · · · · · · · · · · · · · ·
VISION	Attending I r death. ector: After by the funer	atlo	2 Accident investigation	Month, Day Ye	ear) Injury		/ork? □Yes 2□No			
	i Sir de	Certificati	3 Suicide 6 Could not be 4 Homicide determined	lace of Injury uilding, etc. (- At home, farm, s Specify)	street, factory, offic	9	28f. Location (St City or Town		or Rural Route Number,
	Hospital 24 hours a Funerel I	edical C	29a. Certifier Certifying Physician: To Certi	the best of m	ny knowledge, de	ath occurred at the	time, date and plac	e, and due to the coursed at the time. do	ause(s) and mann	er as stated.
	To the Hos within 24 h To the Fur completely	Med	one) and and 29b. Signature and title of certifier	manner stated	d.		nse number			Month, Day, Year)
)	AND AND		Duglun I son	11116	201 1	UD 7	32014	,	6/13/05	
(7		30. Name and address of person who completed	cause of deat	h (Item 23a) (Typi	e Print)	01 -			
			MAWH MOOK OF 31. Date filed (Month, Day, Year)	101 10	G W.	111111	>1- 50	45 541	15/3424	e ans 21889
100	Sta Registr		JUN 1 5 2005	Hereve	J. J.	Coarle				

			1- For State of Maryland / Department of Health Certificate of Death			2005	21445
	Physici /Medic		Decedent's Name (First, Middle, Last) JACK BERT HILL		2. Date of Death Month	Day Year 18, 200	
	Examin	er		GERSTOW			SHINGTON
1	Funeral Director		5. Social Security Number 192–12–3885 6. Sax 1 Months 1 Page 1 Pa	rs Min.	8. Date of Birth (Month, Day, You JULY 14,	1923 PE	thplace (State or Foreign ountry) NNSYLVANIA
	a-f show	ctor	10a. State 10b. County 10c. City, Town or Location BOONS	SBORO			10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28 ast be no	ai Director	10e. Street and Number 141 S. MAIN STREET 10f. Zip Code 217	713	10g	. Citizen of What C	ountry? S.A.
036	72 hours after death with the Maryland Insturel, or Itama 23a or 28a-f show disal Evaniner must be multified at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 No 1943- If Yes, specify Cuban, Mexic of Hispanic Content of Hispanic Conten		city Yes or No- lican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	within ene. then '	Completed	15. Decedent's Education (Specify onfy highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired) SUPERVISO		g	b. Kind of Business	MANUFACTURER
land 2	uld be filed fental Hygi rked other tic evant, I	To Be C	17. Father's Name (First, Middle, Last) 18. Mo		(First, Middle, Ma		
	1 and 2 should be Health and Mental em 27 is marked thar traumatic ev		19a. Informant's Name/Relationship (Type, Print) JACKIE SNAPP, DAUGHTER 19b. Mailing Address (Street and Num 1432 KENSINGTON				
Baltimore,	permit. Pages 1 a Deportment of Hes Important: If Item any njury or otha		20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	6/22/	2005		O, MARYLAND
Balt	permit. Depart Import any nj		21. Signature of Europa Service Liber 9 Rel 21. Name and Address of Fac BAST FUNERAL			NATIONA O, MARYL	
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	n as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death 3 DAYS
8760,	death certificate be executed be attending physician and ad for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Under, hig Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):				YOUNS.
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of de Month	livery Day Year
۵.	8 E 6	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	art I.	23e. Did tobac		o the cause of death?
Vital Records,	The law ate has b page 2 s	Completed			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
of	iding Physician: th. After this certific funeral director,	tion: To Be	examiner? A Hospital: +	Nursing Hom	(Check only one) e 5 Tesidence Bd. Describe how	e 6 Other (Spe	ocify)
Division	tal or Attending Pt s after death, al Director: After th ed in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	Bf. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	Hospii 4 hour Funera ely filla	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dark and manner stated.	e and place, an death occurred	nd due to the caus d at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
)	To the I within 2 To the I complet	M	29b. Signature and title of certifier Diddu 29c. License numbe	56/		Date signed (Mon	th, Day, Year) th 2005
5/H	-Cot1		30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) 2031 LHP/MU DMD BOOMSSON MD	217	713		
	Sta Regist		31. Date filed (Monty 10 av Year) 2005 32. Jegistrar's Signature				

			For State Registrer 1. Decedent's Name (First, M.	iddle Leet		of Maryl	and / Depa	artmen rtificate			and M		Reg. No	0.05	21446
	Physici		Helena G.		gerfoi	cd						Month 6	9 Pay	2005	3:45 PM M
	/Medic Examin		4a. Facility Name (If not instit Casey House					4b. City,		Location o		<u> </u>	1	ounty of Death	,
	Funeral Director		5. Social Security Number 215–26–3678		,]м 2 <mark>М</mark> F	7. Age (In)	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 9 / 28 / 1	th Year)	9. Birthr Washi	place (State or Foreign Try) Ington, DC
	e Maryland ta-f show	ctor	Usual Residence of Decedent 10a. State 10b. Col MD Pri	nty	eorge'		City, Town or Lo		enar	den				1	0d. Inside City Limits 1√2 Yes 2 □ No
	with the	Dire	10e. Street and Number 1517 7th St.					10f. Zip		0706			-	n of What Coul USA	ntry?
356	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo		Armed F	2 No		Was Deced If Yes, spec	ent of Hi			ecify Yes or No Rican, etc.)		Race - Americ Black, White,	etc.
Maryland 21215-0036	within 72 hou lene. Then "nature in Modelle	Completed	15. Dece (Specify only hi Elementary/Secondary (0- 12th	_	e completed) (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Secret	k done d e retired	ition luring mos.)	t of work	ing		of Business/In	dustry
land .	m = 0 %	To Be C	5 - F	nnis	1995							e (First, Middle .ne Hawl		imame)	
	and 2 sho salth and h n 27 is ma	·	19a. Informant's Name/Relat Stephanie A			d/	1517	7th	Stre	et Gl	enar	den, Ma			
nore	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremat 1 ☐ Donation 5 ☐ Other		Removal from	Julia	b. Place of Dispo cemetery, cre		_			Date 5/05		tion - City or To enham . I	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		1. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral 7474 Landover Road Landover, Maryland									l Home			
	Physician /Medical Examiner		23a. Part1. Enter the diseas shock, or heart failure.\ Immediate Cause (Final disease or condition resulting in death)	e, or compl List only o	ne cause on Bro	each line. east C	ancer Wissequence of):						rrest,		Approximate Interval Between Onset and Death
3760,	certificate be executed nding physician and use as the burial transit	dical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												
.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	1 🗀 Live	utcome of pre birth 2 I f mant at time nown	etal death 3[Ectopic pro					230	I. Date of delive Month	ery Day Year
۵.	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant cor	ditions co	ntributing to	death but not	resulting in the u	nderlying ca	ause give	n in Part I.					ne cause of death?
Il Records,	The ate h page	Completed										24a. Was autor perfo	an 2 psy prmed? 2XX No	prior to co death?	psy findings available mpletion of cause of 2 No
t Vital	ysician: Th	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☒No		fospital: 1 □	Inpatient	2 ☐ ER/Outpatie	nt 3 DO	A Othe			n <i>(Check only o</i> me 5 ☐ Resi		Other (Specif) Hospice
Division of	Attending Physician: or death. ector: After this certific by the funeral director,	Certification:	E C / NOO GOIN	nding estigation uld not be	28a. Date (Mo.	of Injury nth, Day Yea	28b. Time of Injury	f 2 M	Bc. Injury Work 1 🔲 `	at ? /es 2 🗍		28d. Describe	how injury o	ccurred	spice
DIXI	P in C		4 ☐ Homicide de	ermined	build	ding, etc. (Sp						City or To	wn, State)		I Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Cert (Check only 2 Med	fying Phy cal Exami	ner: On the	ne best of my basis of exam nner stated.	knowledge, deal nination and/or in	h occurred a vestigation,	in my op	e, date an inion, dea	d place, th occurr	and due to the red at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
ı	To the To the comp	W	29b. Signature and title of ce	tifier	1/)		29c	License	number	21	2	29d. Date s	igned (Month,	Day, Year)
	2(4)		30. Name and address of per Charles Ha				(Item 23a) (Type Muncast	,	11 R	oad F	Rocks	ville.	Marvla	and 208	55
	Sta Registr		31. Date filed (Month, Day, Y	ear)	324	Registrar's S									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien2051 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10:12 AM 2005 Samuel D. Harrison, Jr. June 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Oakland Manor Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Dec. 15, 1 9. Birthplace (State or Foreign Country) Maryland Funeral 7. Age (In yrs. last birthday) Months Days Hours Min. 1X M 2□ F Yrs. 212-03-7868 93 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturat", or itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Maryland Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 Kaywood Place 21784 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2 XNo fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Bus Driver Mass Transit .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 Is marked other t ijury or other traumatic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel D. Harrison, Sr. Mary A. Six ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Harrison 6832 Autumn View Drive Sykesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation = 5 ☐ Other (Specify) Lorraine Park Cem. June 15, 2005 Woodlawn, MD Funeral Service Licenses 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD 21784 23a. Part 1 ty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and D diate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 ₩o 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has this certificate 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 € 100 2 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are:
To the Funaral Dir 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

WJL 10

DHMH 17 Rev 1/2001

State Registrar

29b. Signati

31. Date filed (Month, Day, Year) 2005

555 South Center Street 32. Registrar's Signature

and manner stated

no completed cause of death (Item 23a) (Type, Print)

VISTIMIUSE. MD

	1	For State Registrar	State of Ma		d / Depa		of H	eaith a	nd Me	ental Hy	giene Reg. No	2005	21448
Physician /Medical Examiner		Decedent's Name (First, Middle, Last) Barbara Aa. Facility Name (If not institution, give and the column of the co	Loui.	se		Istv 4b. City, 1	Town, or	Location of	J	Date of D Month UNE	13,	2005 County of De	4:27 P. M
Funeral Director		5. Social Security Number 6. Sec 549–18–6001		(In yrs. 1 84	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	Date of B (Month, D	irth ay, Year,	9. E	Birthplece (State or Foreign Country) alifornia
he Maryland Ba-f show		Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geor	ge's		y, Town or Lo Washing	gton					40- 0		10d. Inside City Limits 1 ☐ Yes 2√√2No
uter death with the Mar interns 23a or 28a-f si internst be routified Eithers Director	2	10e. Street and Number 12501 Monterey Circle	9			10f. Zip	20744	ŀ			log. Ci	tizen of What USA	Country?
NOTE, INSTITUTE A LATE 19-00-50 1985 1 and 2 should be liled within 72 hours after death with the Maryland 11 of Health and Mental Hygiene. 11 Itam 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinat must be rotified at	2	11. Marital Status 1 Never Married 2 1/2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2次次 If Yes, Give Year or Dates:		'	Was Deced f Yes, spec	rfy Cubai	spanic Origi n, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or N can, etc.)	0-	14. Race - A. Black, W Specify:	merican Indian, hite, etc. White
A I A I D-Ut ed within 72 hor ygiene. ner than "natura it, tra Medical E	ווווווווווווווווווווווווווווווווווווווו	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	+)	(Give life.	DO NOT us	k doné d e retired,	uring most	of working	1	16b. F	and of Busine	•
Maryliand A I A I 3-0030 d 2 should be filed within 72 hours aft th and Mantal Hyglene. Z7 is marked other than "natural", or "traumatic event, the Medicul Exami TO Re Commissed by E	0	17. Father's Name (First, Middle, Last) Herbert M. Berger	years 1		ПОП	emker				First, Middle rnbaum		In Ho	me
Te, Maryla 1 and 2 should Health and Men tem 27 is marke other traumatic.		19a. Informant's Name/Relationship (Ty Edwin J. Istvan / Hus	•	20b B		Monter	ey Ci	nd Number rcle F		hingto	n, Ma		e, Zip Code) 20744 or Town, State
DESILLIMOTE, permit. Pages 1 at Department of Hea Important: If Item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ∰⊈remation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	a	emetery, crer as Crema	natory or ot itory	her place	June	15,20	005	Edge	water, M	aryland
permit. Page Department of Important: If any injury or once.	21. Signatur & uneral Service Licensed 22. Name and Address of Facility George P. K. 6160 Oxon Hill Road Oxon Hill,									Home P.A. 0745			
(e be executed / Medical Examiner Parisition Parisiti	ĭ	any leading to innecless cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due	ATED a consequ	uence of): uence of):	NEUMON	NIC 1	EFFUS1	ON				Interval Between Onset and Death 31 DAYS
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- 8 is 9	2	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatie 28a. Date of Injur (Month, Day	у	ER/Outpatier 28b. Time of Injury		Bc. Injury Work	or: 4 □ Nurs	sing Home		idence	6 ☐ Other (S	pecify)
	27. Manner of Death 1 Natural 2 Natural 2 Necident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Injury M 1 Yes 2 No 28c. Injury at Injury M 1 Yes 2 No 28c. Injury at Injury Nort? 1 Yes 2 No 28c. Injury at Injury Nort? 1 Yes 2 No								ļ	City or To	own, Stat	e)	Rural Route Number,
he Hospital in 24 hours a he Funsral i	edical	29a. Certifier (Check only one) 1 ← Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	examina	wiedge, deat tion and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, death	place, an occurred	d due to the at the time	e cause(s o, date an) and manner d place, and c	as stated. lue to the cause(s)
To the within 2 To the complet	Z	29b. Signature and title of certifier	Norm	20	2-1			number 071370	1_T			13, 20	onth, Day, Year)
A (15)		30. Name and address of person who co			23a) (Type, .050 WI	Print)							20762
State Registra		31. Date filed (Month, Day, Year) JUN 1 5 2005	. Registra	ır's Signa	ture				91				

		For State Registrar 1. Decedent's Name (First, Midd)		Maryland		artment o			2. Date of Deat	eg. N2005	2 1 1 1 9
Physic /Medi		Arthur Thomas							Month 06	/10 [/] /2005 ^{Year}	4:38A
Examir		4a. Facility Name (If not institutio		ver)		4b. City, Tow	vn, or Location	of Death		4c. County of De	
		35 Grand Por 5. Social Security Number		Age (In yrs. la	et hirthda v	Oceal If Under 1 Y	n Pines	r 24 Hrs.	8 Date of Birth	Worces	
Funeral Director		200-03-5092 Usual Residence of Decedent	6. Sex M 2□F	87	Yrs.		ays Hours		8. Date of Birth (Month, Day, 06 / 22 / 1	917	rthplace (State or Foreign Country) Pa
yfand how		10a. State 10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits
Be-fs	Director		mico	Ec	den						1 ☐ Yes 2X No
with the or 2	Dire	10e. Street and Number	D I			10f. Zip Co			1	0g. Citizen of What 0	Country?
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or items 23a or 28e-f show event, the Medical Evanture must be rediffed at	by Funeral	11. Marital Status 1 Never Married XXMar 3 Widowed 4 Divorced	12. Was Decede Armed Forc ried 1 ☐ Yes 2 If Yes Give	es? X No	i. 13.		_		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
72 h	letec		nt's Education st grade completed)		(Give	dent's Usual O	one during mo	st of work	ing	16b. Kind of Busines	s/Industry
d 2121 filed within ' Hygiene. other than " ant, the wear	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		<i>DO NOT use re</i> c hasin q	•	t		Governm	ent
e filed other vent.	Be C	17. Father's Name (First, Middle,	Last)			cinasing			e (First, Middle, A		ent
	ToE	Charles Jones					Ada	a Pov	well		
and and sum		19a. Informant's Name/Relation:								City or Town, State,	Zip Code)
		Vivian Jones 20a. Method of Disposition	(wife)	20b. Pfa	ace of Disp	osition (Name o	of			MD 21822 20c. Location - City of	r Town, State
0 0		1 Burial 2 Cremation 4 Donation 5 Other (matory`or other cemeter:		06/13		Osceola Mi	
Baltimore, permit. Pages 1 a Department of Hee Importent: If itsm any injury or othe		21. Signature of Funeral Service		chtei	2	2. Name and A	ddress of Faci	lity Bu	rbage Fu	uneral Hoi MD 21811	
		3a. Part1, Enter the disease, or shock, or head railure. Lis	r complications that cau	sed the death.							Approximate Interval Between
Physician /Medical	ď	Immediate Cause (Final disease or condition resulting in death)		nary A							Onset and Death
8760, cate be executed by sician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any lations to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or	gestive as a conseque	ence of	t Failur	re				
O. Box 6 the death certific y the attending p tched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏Fetalo nt at time of dea	death 3	⊒Ectopic pregn ⊒ Other (specif				23d. Date of d Month	elivery Day Year
ecords, P. law requires that as been signed b	by	Part II. Other significant condit	ons contributing to dea	th but not result	Iting in the t	underlying caus	e given in Part	1.			to the cause of death? Probably 4 □Unknown
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A Falling	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	ig		R/Outpatie 28b. Time o Injury		Injury at Work?		ome 5 Reside 28d. Describe ho	nce 6 XX ther (Sp w injury occurred	Residence
Division or Attending after death. Director: After	Certification:	3 Suicide 6 Could	nined 200. Place o	f Injury - At hon g, etc. (Specify)	me, farm, si				28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
Hospita 4 hours Funeral	edical C	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Physician: To the b Examiner: On the bac and manne	is of examination	/ledge, dea on and/or in	th occurred at the	ne time, date a my opinion, de	and place, eath occur	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
To ths I within 2.	Me	29b. Signature and title of cedific	er /	1		29c. Li	cense number		2	9d. Date signed (Mor	nth, Day, Year)
		Joek .	Sim /			D2	8257			06/11/20	005
H. 10		30. Name and address of person Jock Simon	1			,	nit 5 C)cean	City, N	MD 21842	
St Regist	ate rar	31. Date filed (Month, Day, Year JUN 1	32. Pec	gistrar's Signatu	ure						

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend items 10a & 10b/wich@per fh/6-14-05/dls 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12 2005 Henry Franklin Kyle June 3:25 Р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Dec 24 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1**X**M 2□F ^Y9³7 Kentucky 67 Yrs. 402-52-8722 Director Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Wicomico other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 402-52-8722 Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 900 Booth Street 21801 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruby Thompson Hubert Kyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other trai P.O.Box 421 Benham Ky 40807 Hattie Kyle (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Salisbury Crematory (15/05 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Md. 21. Signature of Funeral Service Licensee Stewart funeral Home Stewar Gladys B. 821 West Rd.Salisbury, Md.21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YPOXIA /Medical Due to (or as a consequence of): **Examiner** PIRATION FUNDNIA Sequentially list conditions, any local productions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine g physician and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed CELEBROVASCULAR 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No CCIDENT VEMENTIA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 1 XNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 105 906051 anyour 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa, MD 614 Easternshore Drive, Salisbury, MD 21804 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State JUN 1 4 2005 Registrar

			1 - For State Registrar	State of Maryland		artment of H			jiene leg. No	005	214	53
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month	th 1 Bay	50,02	3. Time of	Death
	/Medic	al	FRANCIS X 4a. Facility Name (If not institution, give		aGRUT	4b. City, Town, or	Lacation of Dog			unty of Death	10:22	Рм
<i>F</i>	Examin	ęr	Saint Joseph M	edical Cent	er	4b. City, Town, or	Tows		40.00	Balti	more	
	Funeral Director		158-20-6851	x 7. Age (In yrs. I. 7 8	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day December	Ž ^{Ye} 2'8,	9. Birthp	olace (State o ntry) New J	r Foreign erse
	yland tow		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation		·····		1	0d. Inside Cit	ty Limits
	a-fsh	ctor	Maryland Washin	gton H	agers	town					1 🗌 Yes	2 💢 No
	with th	Dire	10e. Street and Number 1270 Jefferson	Dlud		10f. Zip Code 2174	2	1		of What Cour	ntry?	
	he 234	erai		12. Was Decedent Ever in U.	S. 13. ¹			Specify Yes or No-		S.A.	an Indian,	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "naturai; or iteme 23s or 28a-f show any rightry or other traumette event, the Medical Enerth and by redifficial at ODGs.	by Funeral Director	1 □ Never Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Date U.S.Na	avy	f Yes, specify Cuba 1 □ Yes 2 🔀 No	n, Mexican, Puè	Specify Yes or No- rto Rican, etc.)		Black, White,		
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupa	ation during most of we	orkina	16b. Kind	of Business/In	dustry	
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e,	1 and Health am 27		Ina M. LaGrutt 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	1	Hagersto		ion - City or To		<u>-</u>
TOL	ages ent of nt: if it		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, crer	matory or other plac L Cemetery	y 06-2			stown,		and
Baltimore,	partm portar y injur		21. Signature of Funeral Service Licens		/ ²²	. Name and Addres	s of Facility				_	
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മ	death e atter id for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			250	Month	*	'ear
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Records, I	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	þ	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did tol	7.7	contribute to the	ne cause of de ably 4 ⊟U	
ecc	has be	Completed						24a. Was a autops	Sy	4b. Were auto	psy findings a mpletion of ca	available ause of
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Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 X Inpatient 2 □ I	ER/Outpatien	t 3□ DOA Othe	10	eath (Check only on Home 5 Reside		Othor (Specif		
Division of	iding Phy th. : After this funeral d	H .	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho			/)	
Divisi	ii or Attand after death Diractor: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm. str	eet, factory, office		28f. Location (St City or Town		umber or Rura	l Route Numb	ber,
	To the Hospital or Atlanding Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	ie, date and plac pinion, death occ	e, and due to the courred at the time, d	ause(s) and ate and pla	d manner as st	ated. the cause(s)	
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date si	gned (Month.	Day, Year)	
			1 som	me	C	D 30	263		2	18-0	'د	
M	-5		30. Name and address of person who co	ompleted cause of death (Item								
11	Sta	to	FRANCIS TAT-TEE	KHOO, M. D. 32. Fegistrar's Signal	. 760 tuge	U OSLER	DRIVE.	, TOWSON	N. ME	ARYLAN	D 212	1214
	Regist		JUN 2 V ZU	32. Fegistrar's Signat	1. J.	rede !						

		1.	For State Registrar	State of Mary	•		of Health an of Death		Reg. No	105	21454
Physi			Robert L. Lee	•				2. Date of De Month June	Day 8	Year 2005	9:01 A M
Exam	dical niner	4a	. Facility Name (If not institution, give			4b. City, Tow	n, or Location of D	eath		ity of Oeath	1
			Prince George	s Hospital			Chever	1 y	P	rince	George's
Funera Directo			Social Security Number 6. Sr 430-74-1880 1 sual Residence of Decedent	ex ZMM 2□ F	64 Yrs.	If Under 1 Y Months Da		Min. 8. Date of Bi (Month, Di Apr. 8	rth ay, Year) • 1941	9. Birth Cou Ar	place (State or Foreigr ntry) kansas
DESILITIONE, INTERTY ISLA 2 LA 13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If than 27 is marked other than "netural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinar mount be notified at	Funeral Director	10	Da. State 10b. County	George's	c. City, Town or Lo		ingdale		10g. Citizen o		10d. Inside City Limits 1 X Yes 2 □ No ntry?
1th wi	<u>a</u>		3605 Jeff F	load			20	774	U	nited	States
ours after dea rai, or itams	by Fune		Marital Status Never Married	12. Was Decedent Eve Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent If Yes, specify (1 ☐ Yes 2 🗓		? (Specify Yes or No Juerto Rican, etc.)	0- 14. R B	ace - Ameri lack, White, cify: B	
d within 72 hours af giene. "netural", or er than "netural", or the Medical Exam.	Completed		15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	DO NOT use re	one during most of etired)	working	16b. Kind of		•
led w lygier her th	S		7.5.4.4.12.45.45.45.45.45.45.45.45.45.45.45.45.45.	2		Metro T			_	rivat	e
Mar ylarld nd 2 should be file lith and Mental Hy 27 is marked oth	To Be	í	7. Father's Name (First, Middle, Last) Robert L. Le	eks, Sr.			18. Mother's	Name (First, Middle Alth	a M. Br	,	
nd 2 shoulth and 27 is mare treaumer			9a. Informant's Name/Relationship (1					r Rural Route Numb			Code)
attimotory rmit. Pages 1 ar portant: if itam y injury or othal		20	Da. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other	place)	Date	20c. Location	n - City or T	
permit. Pa Departmer Important	ouce.	2	4 Donation 5 Other (Specifical). Significate of Furtheral Service Licen		Ft. Linc	2. Name and A	ddress of Facility	Stewart : d., N.E.	Funeral		
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death certificate be executed death certificate be executed a attending physician and d for use as the burial-transit	Medical E	- IF	F FEMALE:	Coronar	y Athero	scleros	is S/P By	ypass			
She the	Physician/Medical	2	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown]Fetal déath 3[□Ectopic pregn □ Other (specif				Date of deliv Month	ery Day Year
law requires that as been signed b	2	<u>ר</u> ו ב	art II. Other significant conditions of S/P G. 1	ontributing to death but n Cube Placeme		inderlying cause	e given in Part I.		tobacco use co Yes 2 ☐ No		he cause of death?
The The ate h page	Completed							24a. Was auto perf 1 [X] Yes			ppsy findings available impletion of cause of 2 No
Physician: 1 This certificat	Be	3	Was case referred to medical examiner?	Hospital:			Othor	Death (Check only			
Attending Physical Control of the funeral dispersion of the funeral di	atlon: To	1	1 ☐ Yes 2 💢 No 7. Manner of Death 1 🕱 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	2X ER/Outpatie 28b. Time o Injury	28c.	4 ☐ Nursir Injury at Work? 1 ☐ Yes 2 ☐ No	ng Home 5 Res 28d. Describe	idence 6 CC how injury occ		(y)
itei or Attencirs after death	O	building, etc. (Specify)									al Route Number,
To tha Hospitei or within 24 hours after To the Funaral Dir completely filled in	edical	2	29a. Certifier 1 M Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or in	th occurred at the occurred in	ne time, date and p my opinion, death o	place, and due to the occurred at the time	cause(s) and i , date and place	manner as s e, and due t	stated. to the cause(s)
To tha within 2. To the L	M	2	9b. Signature and title of certifier	1 Jan			cense number 5 1 5 2 0		29d. Date sign	ned (Month,	
R6		3	0. Name and address of person who Bahram H	completed cause of ceating is head.			n Ave., S	S.E. #310	, Wash.	, DC	20032
	State strar		1. Date filed (Month, Day, Year) JUN 1 5 200	3.Registrar's							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^D11, 2005 Physician 6:40 Mann June /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5842 Jamestown Road Prince George's Hyattsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😿 F 12/17/1909 Director 578-05-6774 95 Ohio Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits rthan "neture!; or iteme 23e or 28a-f eho the Medical Examiner must be notified at 1 XYes 2 No Director Prince George's 5842 Jamestown Road MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5842 Jamestown Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Heelth end Mentel Hygien important: if item 27 is marked other then any njury or other traumatic event, 122, 806. 12 Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Romana Ciao Joseph Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1066 Hampton Drive, Crownsville, MD 21032 Elaine Greer, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 06/16/2005 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LARGE BOWEL OBSTRUCTION Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of attending physicien end for use as the buriel-trensit Examir certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mooths? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death signed by the aid be detected for 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificete 2 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ funerei To the Mospital or Attending Ph within 24 hours effer deeth. To the Funeral Director; After the completely filled in by the funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29d. Date signed (Month, Day, Year) 29b. Signature and title D24093 TMO 5711 SARVIS AVE RWORDAVE MD 20737 MARK PARKHURST MO Registrar's Signature_ 31. Date filed (Month, Day, Year) State JUN 1 4 2005 Registrar

			State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health		ental Hygi	ene						
			Registrar 1. Decedent's Name (First, Middle, Last)	uncale of Deali		Reg 2. Date of Death	2005	21456					
	Physici	an	Violet Therese Magnesi			Month June	11 2005	12:01 A M					
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location		ounc .	4c. County of De						
	LAGIIII	ÇI	14531 Candy Hill Road	Upper Mari	1boro			George's					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		ler 24 Hrs.	8. Date of Birth	0.6	Birthplace (State or Foreign Country)					
	Director		045-24-4480 1 M 2 KF 72 Yrs.	World's Days Flours	S WINT.	June 22	,1932 Cc	nn.					
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation				10d, Inside City Limits					
	death with the Maryland ms 23a or 28a-f show rmat be notified at	ξ	MD Prince George's Upper	Marlboro				1 XYes 2 No					
	r 28a	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What	Country?					
	h witt		14531 Candy Hill Road	20772			USA						
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic C f Yes, specify Cuban, Mexic	Origin? (Spec	ify Yes or No-	14. Race - Ar Black, W	merican Indian,					
20	hours after tural', or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	☐ Yes 2 No Specif		,							
9500-61212	be filed within 72 hours after death with the Manylan tal Hygiene. d other than "natural", or Items 23s or 28s-f show event, I're Medical Exactinar man be notified at			lent's Usual Occupation		11	6b. Kind of Busine	hite					
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Mar	12 sh h and 7 Is m traum			g Address (Street and Num									
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ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es			Hwy.	Bowie,		715						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such a	as cardiac or	respiratory arres	st,	Approximate Interval Between					
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Ţ.	n requires that the deben signed by the should be detached	/ Physic	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part	rt I.	23e. Did toba	cco use contribute	to the cause of death?					
dS	requires leen sign hould be	d by				1 ☐ Yes	2 No 3	Probabiy 4 □Unknown					
Kecord	law red as beer 2 shou	jete				24a. Was an	24b. Were	autopsy findings available					
	9 4 9	Completed				autopsy performe	d? death	o completion of cause of ? es 2 □ No					
VII	ysiclen: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Pla	ace of Death (Check only one)	100	53 2 110					
) IO	Physiclen: this certific ral director,	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		Nursing Home	e 5 Residen	ce 6 □Other (S)	pecify)					
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2	after Direct	Certification:	4 Homicide determined building, etc. (Specify)	set, factory, office	20	City or Town,	State)	Aufai Aoute (Vuiriber,					
	To the Hospitel or Attendl within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier Certifying Physician: To the best of my knowledge, death	occurred at the time, date a	and place, an	d due to the cau	se(s) and manner	as stated.					
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	To the within To the comple	Σ	29b. Signature and title of certifier	29c. License number	(A)	290	d. Date signed (Mo	nth, Day, Year)					
	00/5		retal residence	KO)A	0-4		6/11/0	17					
	UNU		30. Name and address of person who completed pauls of death (Itel 23a) (Type	THE ROSA) Aur	WAPID!	Sam 2	(401					
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature		/ 110	,-1,100	<u> </u>	(())					
	Registr	ar	JUN 1 4 2005 Section & April	E .									

			For State Registrar	State	of Maryla		artmen rtificat			Mental Hyg	giene 10g. No2 (005	21157
	Physicia /Medic		1. Decedent's Name (First, Mid Bessie		erritt	_				2. Date of Dea Month	Day 13	Year 2005	3. Time of Death 1 435 M
	Examin		4a. Facility Name (If not instituti				4b. City,	Town, o	r Location of Dea	th		nty of Deeth	
A.,	Funeral		Atlantic Gene 5. Social Security Number	ral Hospi		s. last birthday	Ber If Under	1 Year	If Under 24 Hrs	s. 8. Date of Birth	1	cester 9. Birthp	place (State or Foreign
,	Director		214-46-2526	1□M 2 1□F	94	Yrs.	Months	Days	Hours Min	7/1/19		MD	ntry)
50,	land w	}	Usual Residence of Decedent 10a. State 10b. Coun	у	10c. C	City, Town or L	ocation					1	0d. Inside City Limits
GP071	the Marylar 28a-f ehow	Director	MD Word	cester	E	Berlin	10f. Zip	Code			10g. Citizen	of What Cour	1 ☐ Yes 2 🛣 No
000B	72 hours after death with the Maryland Insturel', or Items 23a or 28a-f ehow disal Examinat nust be notified at	by Funeral	10714 Sinepux 11. Marital Status 1 Never Married 2 Marital 3 Midowed 4 Divorce	12. Was De Armed	cedent Ever in Forces? 2 2 No Sive Dates:	U.S. 13.		2181 dent of H cify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	US		ean Indian, etc.
557E	- 9	Completed	(Specify only high Elementary/Secondary (0-12	ent's Education est grade completed College	d) (1-4or 5+)	(Give	DO NOT u	rk done se retired	during most of wi	orking		f Business/In	
स्वर्	filed within Hygiene. other then	Co	8 17. Father's Name (First, Middle	a. Last)		Home	emake	r	18. Mother's Na	ame (First, Middle,		n Hom	ie
B & B	should be nd Mental marked o	To Be	John "Jink" D							Hudson			
Mary	s i and 2 should be filed within f Health and Mental Hygiene. Item 27 le marked other than other traumatic event, The M		19a. Informant's Name/Relatio Theodore I. M	nship (Type, Print)	nn -					Rural Route Numbe			Code)
子子。			20a. Method of Disposition 1 Disurial 2 Cremation		20b.	. Place of Disp cemetery, cre	osition (Nar	ne of		Date	20c. Location	on - City or To	own, State
SUE	nit. Page artment o ortant: If injury or		`4 □ Donation 5 □ Other	(Specify)		Faylory	ille C	eme		16/2005			
SST	permit. Pag Department Important: I eny injury o once.		21. Sign aire i une al Servic	Julas			108 W	illia	m Street	he BUrb , Berlin,	MD:		Home
1435	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. L' Immediate Cause (Final disease or condition resulting in death)	a. Due t	t caused the den each line. 18 UMC o (or as a conse	equence of):	iter the mod	le of dyir	ng, such as cardia	ac or respiratory an	rest,		Approximate Interval Between Onset and Death
100	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infilated events resulting in death) Last	c. Due t	o (or as a conse o (or as a conse o (or as a conse or on ic	equence of): Twe + equence of): Oh sh	tear truct	T five	Failur. Pulmo	nary E	rseas	2	
P.O. Box 68760	that the death certificated by the attending placed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live	outcome of preg birth 2 Fe gnant at time of known	etal death 3	□Ectopic pi □ Other (sp		у		23d.	Date of delive Month	ery Day Year
	quires that n signed b	by	Part II. Other significant cond	tions contributing to	death but not re	esulting in the $\mathcal{U}_{\mathbf{X}}$	underlying o	ause giv	ven in Part I.		bacco use d		ne cause of death?
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	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical (29a. Certifier 18 Certification (Check only ane)	ying Physician: To al Examiner: On the and m	the best of my k basis of exami anner stated.	knowledge, dea ination and/or i	ith occurred nvestigation	at the til	me, date and place opinion, death occ	ce, and due to the courred at the time, o	cause(s) and date and place	manner as s ce, and due to	tated. o the cause(s)
	To the within To the comp	Ž	29b. Signature and title of cert	fier /		11.5	29	c. Licens	se number		. 1 6	ned (Month,	Day, Year)
			Gegery !	1. Jai	unis	MU)	1	206	512	6	13/2	05	
0	H. 3		30. Name and address of ers	Tamha	suse of death (It	em 23a) (Type	Hoal	Hala	INDY	Berlin, L	11) 21	1811	
	Sta Regist		31. Date filed (Month, Day, Ye	5 2005 32	legistrar's Sig	nature	mele	1	1-1	-		-	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 **Physician** Month Lillian Hilda Mays June 13, 2:45 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Manchester Long View Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F Yrs Director 216-03-9790 91 1914 31, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "naturel", or items 23a or 28e-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits other treumstic event, the Mudical Examinar must be notified at Westminster 1 ☐ Yes 2√ No Director Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21102 1616 Manchester Road USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ∐Yes 212 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 ☑ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Clothing Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edward Singer M. Lucinda Weaver ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lynn Siegman, daughter 1616 Manchester Road, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny in]ury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Wesley Cemetery 06/16/2005 Hampstead, MD 21. Signature of Funeral Service Licenşee 22. Name and Address of Facility MG0723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 100 /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Year-Due to (or as a consequence of): Examiner To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificate has 1 🗆 Yes 2 No Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 Tyes 2 No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) WI 3316 0 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

		For State Registrar		State of Ivia	•	•	tificate of	ieaith and iv Death	тепіаі пу	Reg. N			
9		Decedent's Name	(First, Middle, Las	st)					2. Date of De		2005	2. Time of Square	
Physicia /Medic				EMORY	EUGENE	: M:	ILLER			12,	2005	6:00 A M	
Examin			_	street and number)				Location of Death		4	c. County of Death		
		5. Social Security Nu	R COURT		e (In yrs. last bin	*h da.d	UNION If Under 1 Year	BRIDGE If Under 24 Hrs.	O Data of Bi		CARROL		
Funeral Director		219-34-2 Usual Residence of	394	7. Age		Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di 4 / 3 / 1			place (State or Foreign ntry) *LAND	
yland iow		10a. State	10b. County		10c. City, Town	n or Lo	cation					10d. Inside City Limits	
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ath with the Marylar 23s or 28s-f show	I Director	10e. Street and Num 858 STA	R COURT	•			10f. Zip Code	1791		10g. C	Citizen of What Cou	ntry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinating traumatic at an once.	y Funeral	11. Marital Status		12. Was Decedent I Armed Forces? 1 Yes 2 No If Yes, Give			Vas Decedent of H f Yes, specify Cuba □ Yes 2X No	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White,	, etc.	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of deliv Month	ery Day Year	
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TOT Within	Me	29b. Signature and t	title of certifier	nte	My		29c. Licensi	3530	12	29d. D	ate signed (Month,	Day, Year)	
5		30. Name and addre	ss of person the	completed cause of de	eath (Item 23a) (Турв, Г	enter Str	cot lik	35/11/10 S	ster	COM,	1157	
Sta Registr	_	31. Date filed (Monti	JUN 13		ar's Signature	•	breed .						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan		artment of F			iene •g. N2 0 0 5	211.50
ı	Physic	ian	Decedent's Name (First, Middle, Last, TOTALT					2. Date of Deat Month	h Dav Year	3. Time of Death
	/Medi Examir		HENRY MICHAEL] 4a. Facility Name (If not institution, give			4h. City. Town, o	r Location of Deat	DV~	15 200 à	
	Lxamii	ICI	309 Kingswood Te	-		Hagers			,	on County
	Funeral Director		145-14-2040	7. Age (In yrs. I M 2 F 82	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Nov. 15	Year) 9. Bi	rthplace (State or Foreign country) W Jersey
	yland Now		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation			<u> </u>	10d. Inside City Limits
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	with the	Funeral Director	10e. Street and Number 309 Kingswood Tern	caco		10f. Zip Code 21742		10	0g. Citizen of What C	ountry?
	death ms 23	nera		12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	U.S.A.	erican Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents if item 27 is marked other then "neturel", or Items 23e or 28a-1 show my injury or other treumatic event, the Medical Exercit at most be recitled at ance.	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes 2 🙀 No	an, Mexican, Puerl Specify:	o Rican, etc.)	Specify: W	hite hite
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Baltimore,	es 1 and 2 of Health fitem 27 I r other tre		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of natory or other place			20c. Location - City or	
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_	Funeral		DOCTOR'S HOSPTI. 5. Social Security Number 6. Se		y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
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0030	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "naturel", or Iteme 23e or 28e-1 show other then "naturel", or Iteme 23e or 28e-1 show event, the Medical Exprinit references be rediffical at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto □ Yes 2♥ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
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	2 should be and Mental is marked is umatic ev	ř	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Ma	iling Address (Street and Number or Run		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** Ollie F. Pratt 2.005 June 9 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Severn If Under 1 Year 1704 Meade Village Circle Anne Arundel Hours Min. Jan 30 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 5. Social Security Number 217-62-9566 **Funeral** 51 Months Days 1 XM 2 ☐ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Maryland Anne Arundel Glen Burnie Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21061 USA 2800 Kramer Ct. Apt 2C Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) R.S. Leitch Co. Truck Driver 12th Pages 1 and 2 should be filed w riment of Heelth and Mental Hygie rtant: If Itam 27 Is marked other t njury or other traumatic event, IL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Francis Hawkins Arthur Pratt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angela Parker(Daughter) 919 G Royal St. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Depertment of Important: If any Injury or once. 6-16-05 Drury, Md. Moses Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 21. Signature of Funeral Service Licensee B. Keese MOG483 Tarry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive cardiovascular disease atheroscleratic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed inding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş coholism 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 \sum No 24a. Was an certificete has b autopsy performed? 1 Yes 2 🗆 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: $4 \square$ Nursing Home $5 \square$ Residence 6×10^{-1} Sther (Specify) SCENE 1 XYes 2 □ No 2 ER/Outpatient 3 DOA 1 Inpatient ihis 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C completely filled it 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number hi OCME June 9, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) man LING 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar

State

JUN 1 4 2005

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 2^{Day} MARGARET 2005 STAVELY PAYNE 6:59p /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospital Center Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 1, Day 86 Director 212-16-7734 Aug 1918 Maryland Usual Residence of Decedent the Maryland 10a. State show 10b. County 10c. City, Town or Location item 27 is markad other then "naturel", or Items 23e or 28e-f show other treumatic event, the Madical Examinations to swifted at 10d. Inside City Limits Director MD Kent Worton 1 ☐Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 26096 Lambs Meadow Rd. 21678 U.S.A. Funerai death 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or lies any injury or other treumsting. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Kent County Elementary/Secondary (0-12) College (1-4or 5+) Secretary Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Reyner Wroth Stavely Pauline Copper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Meikle (daughter-in-law) P.O. Box 78 Worton, MD. 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State I.U. Cemetery * 4 ☐ Donation 5 ☐ Other (Specify)-6-27-05 Worton, MD. 21. Si mature of Funeral Servio Licensee 22. Name and Address of Facility
Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD. 21635 Approximate Interval Between Onset and Death 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final Hemore Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be axecuted the burial transit Due to (or as a consequence of): Box 68760, physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 No the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ pe Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page autopsy perform certificate Division of Vital 1 ☐ Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ★Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 5 Pending death. 2 Accident investigation Director: 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af
To the Funere! D
completely filled i Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day Year) 124 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Patrick Shanahan, M.D. 120 Speer Rd. Chestertown, MD. Registrar's Signature State 8 2005

Registrar

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_		Physici		1. Decedent's Name (First, Middle, Last, Anna Ruth Poo					2. Date of Dea Month June	ath Day	3. Time of Death 3:00 A M
		/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	buile	4c. County o	
				Upper Chesapeake N			Bel A				rd County
		Funeral Director		5. Social Security Number 6. Set 413–28–0423 Usual Residence of Decedent	7. Age	o (In yrs. last birthd 78	Months Davs	Hours Min.	8. Date of Birt (Month, Da July 2	1926	9. Birthplace (State or Foreign Country) Alabama
336		Maryland f show	or	10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 Tyes 2 No
03		s after death with the Marylan , or Items 23a or 28a-f show caminar must be notified at	Funeral Director	Maryland Hartfo		Belcam	10f. Zip Code	017		10g. Citizen of Wi	<u>-</u>
		ns 23	era	1123 Belcamp Gart	12. Was Decedent I	Ever in U.S.		017 Hispanic Origin? (Sp.			- American Indian,
	980	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28e-f show he Mcdfeal Examinat must be notified at	ρ	1 ☐ Never Married 2 ☐ Married ③ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	ło	3. Was Decedent of lif Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black Specify:	White, etc. White
	21215-0036	hin 72 hours s. in "neturel"; Medical Exa	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5	(G	cedent's Usual Occu ive kind of work done e. DO NOT use retire	during most of work	ing	16b. Kind of Bus	iness/Industry
	21	giene giene er tha	Com	12			Owner Re	estaurant_		Restaur	
10	Maryland	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than any injury or other freumatic event, Ins. M. On	Fo Be	17. Father's Name (First, Middle, Last) John Hargrove				18. Mother's Name	e (First, Middle, MOWN	Maiden Sumame)
6/14/05	Mary	and 2 should leadth and Men not 1s markener treumatic		19a. Informant's Name/Relationship (Ty Wesley M. Poole	(Son)		ailing Address (Stree Mauser Di			er, City or Town, S yaldn 21	
6/1	Baltimore,	ges 1 ar it of Hea if item or other		20a. Method of Disposition 1 🗡 Burial 2 🗆 Cremation 3 🗆 F	·····	20b. Place of Di cemetery,	sposition (Name of crematory or other pla	ice)	Date	20c. Location - C	ity or Town, State
	altim	nit. Pa partmen ortent: injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 	99	Cedar I	awn Mem Pa 22. Name and Addr	and of Facility	2 16 05		own Maryland uneral Home
	ä	permit. Departi		Y Dunla	& Ti	ing 1	1331 Easte		with the second		aryland 21742
_		Physician		23a. Part1. Enter the dise se, or complete shock, or heart folders. List only or immediate Cause (Final	ications that caused ne cause on each lin	the eath. Do not ie.	enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	7	Physician /Medical Examiner		disease or condition resulting in death)	Due to (as	a contequence of):	ndial 1				0,
		cuted id ansit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):	aton a	ccident		-	7 year
31	3760,	ate be executed hysician and he burial-transit	ca	resulting in death) Last	Due to (or as add.	a consequence of):					
4227	P.O. Box 68	Attending Physicien: The law requires that the death certificate r death. ector: After this certificate has been signed by the attending physiby the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	ey		23d. Date Mont	· ·
#	ds, P.	uires that the de: signed by the a Id be detached f	by	Part II. Other significant conditions co	ntributing to death but the tributing to death but the tribution of tribution of the tribution of the tribution of tri	•	e underlying cause gr	ven in Part I.	23e. Did to	1	oute to the cause of death?
	cor	aw requiras been si 2 should l	Completed		2(10010				24a. Was	, -	ere autopsy findings available or to completion of cause of
	E Re	ysicien: The lav is certificate has director, page 2	Com							rmed? de	ath? ☐ Yes 2☐ No
)	Vita	sicien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	· den	Ot	26. Place of Death			
Anna	Division of Vital Records,	ding Phys h. After this funeral di	tion: To	27. Manner of Death 1 ((A)Natural 5 Pending	1 ☐ Inpatie 28a. Date of Injui (Month, Day	y 28b. Tim	e of 28c. Inju	4 Nursing no		dence 6 Other	
	Divisi	l or Atten after deat Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm. c. (Specify)	street, factory, office	-	28f. Location (5 City or Tox		or Rural Route Number,
Poole		To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best oner: On the basis of and manner sta	examination and/o	eath occurred at the tr investigation, in my	ime, date and place, opinion, death occurr	and due to the cored at the time,	cause(s) and mandate and place, an	ner as stated. d due to the cause(s)
4		To the within To the comple	Me	29b. Signature and title of certifier	Mu	mn	29c. Licen	se number		/ 1	(Month, Day, Year)
^	5H-	5		30. Name and address of person who or	ompleted cause of d	eath (Item 23a) (Ty	pe, Print)	ne Mail	111	200 A.	Mn21014
0	וו	Sta	ate	31. Date filed (Month, Pay, Year) 7 2	32. Pagistra	ar's Signature	Sperke	ne l'our	100/	rec 1100	, / (
	4	Regist	al		1	/					

			For State Registrar	State of N	laryland / Dep. <i>Ce</i>	artment of H			iene 2005	211.65
	Physici	an	1. Decedent's Name (First, Middle, I		Phillip			2, Date of Dear	th Day Year	3. Time of Death
2.	/Medic Examir		4a Facility Name (If not institution, g	ive street and number		4b. City, Town, or	Location of Deal	June	4c. County of De	
			757 Spruce Stre			Hagerst			Washi	
П	Funeral Director		5. Social Security Number 6. 217-78-6617	Sex 7. A 12⊠M 2 ☐ F	Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1962 Ma	irthplace (State or Foreign Country) 1 ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	n the Maryland r 28a-f show modified at	ctor	Maryland Washi	ngton	На	gerstown				1 1 Yes 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 757 Spruce Str	eet		10f. Zip Code	740	1	0g. Citizen of What C	Country?
	items 2%	ınera	11. Marital Status	12. Was Deceder Armed Forces		Was Decedent of Hi	spanic Origin? (S	Specify Yes or No-	14. Race - Arr Black, Wh	
920	a o ∃	þ	1 ☐ Never Married 2 ☐ XMarried 3 ☐ Widowed 4 ☐ Divorced] No	1 ☐ Yes 2 🛣 No	Specify:	,	Specify: W	
21215-0036	"neturel",	Completed	15. Decedent's (Specify only highest of	Education prade completed)	(Give	dent's Usual Occupa kind of work done d	uring most of wo	rking	16b. Kind of Busines	s/Industry
212	d withir giene. er than the M	omo	Elementary/Secondary (0-12)	College (1-40	r 5+)	po NOT use retired; rectional		r	prison	
	l be file ntal Hy ed othe event.	Be	17. Father's Name (First, Middle, La David Howard Ph					me (First, Middle, M	Maiden Surname)	
Maryland	should ind Me is mark umatic	၉	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street a			, City or Town, State,	Zip Code)
	and 2 ealth a m 27 is		Pamela L. Philli	ps - wife	6821	Tommytown		harpsburg	g, Md. 217	82
nore	ages 1 ant of H nt: if ite y or oti		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		B)	osition (Name of matory or other place wn Cremato			20c, Location - City o	r Town, State , Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netur any injury or other treumatic event, the Madicial ODGE.	Ì	21. Signature of Funeral Service Lice	•	22	2. Name and Address	s of Facility MI	NNICH FUN	VERAL HOME	•
	± 0 = 0		23a. Part1. Enter the disease, or co	mplications that cause					stown, Md.	
	Physician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)		tact gu, s a consequence of):	u shot	(2004	id to	Head	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of): s a consequence of):					
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Records, P	w requires that the been signed by th should be detache	Ď	Part II. Other significent conditions	contributing to death	but not resulting in the u	nderlying cause give	n in Part I.	1 □ Ye	s 2 □ x 6 3 □ P	o the cause of death? robably 4 Unknown
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	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	hysician: To the bes	t of my knowledge, death of examination and/or inv	occurred at the time vestigation, in my opi	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and manner s	natos.	29c. License	number	29	d. Date signed (Mon	th, Day, Year)
			Schworth	Ditto	TI MO		1062	J	une 10	, 2005
H-5	5		30. Name and address of person who Edward W. Ditto,	III, M.D.			ace Rd.	, Hagerst	own, Maryl	land 21742
:	Sta Registr	te ar	31. Date filed (Month, Pay Year) 6	2005 32. Redis	trar's Signature	neke				

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Olive 1 genia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner lestminste Year If Under 24 Hrs. ar-0 ento 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year 9. Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 🔀 F 87 364-01-2125 NEB Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other treumatic event, Ite Madical Examination until be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No Director Carroll Westminster MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 45 Washington Road 21157 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hazel Holder Minor B. Williams ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1816 Bowersox Road New Windsor, MD James Price/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 06/13/2005 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation, Inc Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eumonia 1 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ō in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an this certificate has autopsy performed? page 2 2 300 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Anpatient Certification: To 1 Yes 2 100 2 ER/Outpatient 3□ DOA 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred efter death. Director: After Injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of sertifier WS 1)005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Willow Kurs 31. Date filed (Month, Day, Year) ar's Signature State Registrar

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of Vi	ye sign	ToB	examiner?	Hospital: 1 🗌 Inpatient		Other	26. Place of Death T 4 Nursing Hom		ce 6 □Other (Specify)
n	Jing After funer	ertification;	27. Manner of Death 1	28a. Date of Injury (Month, Day			at 2 ? es 2 \(\text{No} \)	8d. Describe how	injury occurred	
Div	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	OF	4 Homicide determined	building, etc.				City or Town, :	State)	r Rural Route Number,
	the Hos in 24 ho he Fun pletely	edical	(Check only one)	/sician: To the best of iner: On the basis of e and manner state	xamination and/or invi	estigation, in my opi	inion, death occurre	d at the time, date	and place and	due to the cause(s)
)	. vith	Σ.	29b. Signature and title of certifier	Nama	In the (Item 23a) (Type, P	29c. License	number 3655	_ · 29d	Date signed (M	onth, Day, Year)
	5		30. Name and address of person who c SABAHAT WAV	ompleted cause of deal VAB , 32	th (Item 23a) (Type, P	te DR:	GRANT	SVILLE	MO	21536
	Sta Registra		31. Date filed (Month) DN 2" 8 2	005 32. Sistrar'	s Signature	and a				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robinson Neva Mae 06 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Sacred Hospital Heart If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb 27, **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 2 □ F Hours 1934 Director 236-50-2335 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or Items 23e or 28e-t show the Wedical Examinat must be notified at MD Allegany Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Dunbar Drive 21502 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. permit. Rages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neturel", or her eny injury or other traumain. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) owner/operator MD Avenue Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bejamin Franklin Robert Wolfe Provo Madelaine Gray Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 745 Fayette Street Don Robinson son Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 6/25/2005 * 4 ☐ Donation 5 ☐ Other (Specify) LaVale MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA If Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Part Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Class Immediate Cause (Final disease or condition resulting in death) Heo VT allure Physician /Medical (or as a consequence of) Examiner Hear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Records, P.O. Box 68760. signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4⊡Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by dues 2. No 3 ☐ Probably 4 ☐ Unknown Completed diale 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No Division of Vital 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 0 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred al or Attending Patter death.
I Director: After After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospitel or within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of cort 29c. License number 29d. Date signed (Month, Day, Year) D13601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. VICTOR Felipa .925 Bishop Woust Road Cumberland HD. 21502 31. Date filed (Month, Day, Year)
JUN 2 8 2005 32. Resistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	rylailu /	•	ficate of			Reg. No. 2	105	211.	7.0
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	yland		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, To	own or Locat	ion				1	0d. Inside City Lin	
	Ma office	Director	MD Carroll		Syk	esvil]	Le					1 ☐ Yes 2X	No
	1 th	<u>=</u>	10e. Street end Number				10f. Zip Code			10g. Citizen of W	/het Coun	try?	
	15 wi	ai	2021 Rudy Serra Dr	rive #2C			21784			United	State	es	
20	72 hours after death with the Maryland natural; or Nerne 23e or 25e-f show deal Examiner must be notified at	by Funeral	11. Marital Status 1 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Event Armed Forces? March Yes 2 Note of Yes, Give Year or Dates:			s Decedent of bes, specify Cub	hispenic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	Blac	- Americ k, White, Whi	etc.	
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0	e filed Il Hygi other		17. Father's Neme (First, Middle, Lest)			1 4111		18. Mother's Nar	ne (First, Middle,	Maiden Surnam			
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2	2 should end Men is marke aumatic	F	19a. Informant's Name/Relationship (Typ	oe, Print)	1	9b. Mailing	Address (Street	and Number or Ru		er, City or Town,	State, Zip	Code)	
S	4 T = 4		Rosabell U. Razgait			2021 B	andy Son	ra Dr. #	2C Sylv	cvillo	MD	2178/	
<u>ق</u>	f Heal fram 2 other	-	20a. Method of Disposition	.15 WITE	20b. Place	of Dispositi	on (Name of		Date	20c. Location -	City or To	wn, State	
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Ba	permit. Peges Department of Important: if it any injury or once.		· Milk	all.		Bur	rier-Qu	ieen Fune d Libert					
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the	he death. D	o not enter t	he mode of dyi	ng, such es cardia	or respiratory e	rest,	110 2	Approximate Interval Between	
A.	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth) a.	Ai	lue to (or as			ntre	Vinen	lm J.	2	Onset and Death	
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Вох	ath o	lan											
о <u>.</u>	at the death cert I by the attending stached for usa	Physician/M	Part II. Other significant conditions cont	ributing to death but	not resulting	g in the unde	erlying cause gi	en in Part I.	23b. Did	lobacco use cor	tribute to	the cause of dea	ath?
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of Vital Records,	sw requii s been s 2 should	Completed b							24a. Was	en autopsy med?	ava	ere autopsy finding allable prior to appletion of cause death?	
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ā		Be	25. Was case referred to medical					26. Place of Dea	ath (Check only o	nne)			
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	D D		27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey	Year) 28b	. Time of Injury	28c. Inju Wo M 1			now injury occurr			
Division	al or Attending s after deeth. i Director: After id in by tha fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, street	, factory, office		28f. Location (City or To	Street and Numbern, Stete)	er or Rura	l Route Number,	
	To the Hospital or A within 24 hours after To the Funerei Directompletaly filled in b	edicai (29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier Phys	ician: To the best of er: On the basis of e and menner stets	xamination :	ge, death or and/or inves	ccurred et the ti tigation, in my o	me, date end plece opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)	
	To the within 2 To the comple	ĕ Z	29b. Signature and title of certifier	1			29c. Licen:	se number		29d. Date signed	(Month,	Day, Year)	
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_	5		30. Name en fladdress of person who con	e Roll	W.L	5/1/h	Mote	JOHN W.	2/1	57	() de .		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 3	32. Registrar 2005	's Signature	K 1	book						

Vincent Smith 05-03956 RJ

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/Medi	ian	1. Decedent's Name (First, Midd Vincent			e /Officalle of			2. Date of Deat Month June 9	0-	year Year	6:47 a
Exami		4a. Facility Name (If not institution		ber)	4b. City, Town,	, or Location	of Death	ounc)	4c. County	y of Death	0.47 a.
	iei	Prince George's	=		Chever	:ly				e Geo	rge's
ineral rector		5 Sacial Sacurity Number 5 78 - 78 - 5685	6. Sex 7 1 ☐ M 2 ☐ F	. Age (In yrs. last birthda 48 Yrs.	y) If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day,			lace (State or Foreighty) h., DC
>		Usual Residence of Decedent 10a, State 10b, County	,	10c. City, Town or	Landing						
od other than "natural", or liems 23a or 28a-f show event, the Modical Examinat must be notified at	tor		ce George's		Location	Lando	ver				0d. Inside City Limi 1X1Yes 2 ☐ N
1.28s	Director	10e. Street and Number			10f. Zip Code	•		10	Og. Citizen of	What Count	try?
23a c		2210 Orego	n Ave.			207	'85		Unit	ed St	ates
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al, or	þ	1 X Never Married 2 Mar 3 Widowed 4 Divorce	If Yes Give		1 ☐ Yes 2🌠 N	lo Specify:	:		Specif	fy: B1	ack
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		Barbara A. S	mith - Moth	ner	2210 Or	egon A	ve.,	Landove	r, MD	2078.	5
or oth		20a. Method of Disposition 1 □x8urial 2 □ Cremation	3 Removal from St	cometent c	position (Name of rematory or other pi	lace)	Da	ate 2	20c. Location	- City or Tov	wn, State
ant: I		'4 □Donation 5 □ Other (Memorial	Park	6/15/	2005	Lan	dover	, MD
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Helen Smith 2005 June /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Camp Springs
Under 1 Year If Under 24 Hrs.
onths Days Hours Min. Prince George's Malcolm Grove Medical Center If Under 1 8. Date of Birth 1942 9. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdav) **Funeral** Months 1 M 2X F Yrs. 63 Rocky Mount, NC Director 102-34-1478 20 January Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b County 10a. State 10d. Inside City Limits il Hygiene, other then "naturel", or Items 23e or 28e-1 show vent, I've Medical Exactit er result be notified at XXYes 2 No Directo MD Prince Georges Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 20746 5000 Lydianna Lane Apt#201 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ∐Yes 2★ No If Yes Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) **10th** College (1-4or 5+) Homemaker Private treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be it of Health and Menfal Robert Lee Hart Sr. Cornelia Brown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Smith Sr./Husband 5000 Lydianna Lane Apt#201, Suitland, MD 20746 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ¹ 4 □ Donation 5 □ Other (Specify) Rosedale Cemetery 6/16/05 Linden, New Jersey 21. Signalore of vinera Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of) Examiner Sarcoidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2▼ No 24a. Was an autopsy performed? 2**X** No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 Inpatient 2 A ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours affer death. investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46052 6/10/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sjoerd Beck, 600 Ridgely Ave. Suite#121, Annapolis, MD 21401 31. Date filed (Month, Day, Year)
JUN 1 4 2005 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For Stete Registrar 1. Decedent's Name (First, Middle,	State of Marylar		artment of H		-	Reg. No. 2	05 214.75
	Physicia /Medic Examin	an al -	Rachel 4a. Facility Name (If not institution,	E Snith		4b. City, Town, o	or Location of D	Month	Day 4c. County of	Year 268 P M
	Funeral	ÿ.	5. Social Security Number	el Mudical (5. Sex 7. Age (In yrs.		If Under 1 Year Months Days	Polis If Under 24		A me	A () (
	Director	-	212-14-9746 Usual Residence of Decedent 10a. State 10b. County		3 Yrs.			Oct 1		Maryland 10d. Inside City Limits
	the Maryi 28a-f sho	Director	Maryland Anne		napoli				10g. Citizen of W	1X Yes 2 □ No
:	3a or	D	20 Parole St.			2140	1		USA	
036	inin 72 nours after death with the Maryland an "naturel", or items 23s or 28s-1 show Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cub	dispanic Origin an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)		- American Indian, K, White, etc. Black
215-0036	within 72 ho lene. than "natur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of d)		16b. Kind of Bus	ŕ
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	rau	K	Charlotte Brow			-		napolis,		
o	of H fitar roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of C		Place of Dispo Pa Pa	sition (Name of reconfigureOre r]{	riva1 6-	Date -16-05	20c. Location - (Annapol	ity or Town, State
Balti	perrit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li	censee	W 8	Name and Addre M. Rees 21 West	e & Sc St. 1	ons Mort Annapoli	uary, P s, Md.	.A. 21401
1	nysician /Medical	v. Ni yi	23a. Part 1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. Hypox	th. Do not ent					Approximate Interval Between Onset and Death
3760,	ate be executed with sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Chronic (quence of):	uet Ne	e Pul	money	Disca	se years
ĕ.	death certific e attending p nd for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 6	al death 3	Ectopic pregnanc Other (specify)	y		23d. Date Mon	of delivery th Day Year
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Division of	ding Phys h. After this funeral dis	tion: To	1 Yes 2 76 27. Manner Death 1 1 atural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injui Wor	ry at	ng Home 5 Resi 28d. Describe	dence 6 Othe	
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	To the Hospital or Attan within 24 hours after deat To the Funarai Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physicien: To the best of my kn exeminer: On the basis of examin- and manner stated.	owledge, death ation and/or in	occurred at the tivestigation, in my o	me, date and popinion, death of	lace, and due to the occurred at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)
	To II To II	Me	29b. Signature and title certified	1		29c. Licens	se number	7	29d. Date signed	(Month, Day, Year)
			X . \ . \ \	who completed cause of death (Ite	٨	,	> Me	dical 7	Parku	an
	Sta Registi		31. Date filed (Month, Day, Year)	Registrar's Sign	ature	apolis,	m)	C1701		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Doparts of Double with Maryland

		For State Registrar	State of Maryland	d / Department of Health an Certificate of Death	Reg	No 105 21176
Physici	an	1. Decedent's Name (First, Middle, La			2. Date of Death Month	Day Year
/Medic		Leonard	Satloff			0 . 2005 0205 4c. County of Death
Examin	ner	4a. Facility Name (If not institution, gir		4b. City, Town, or Location of E	eath	
			Sex 7. Age (In yrs. la	ast birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	9. Birthplace (State or Forei
Funeral Director			1⊠ M 2□F 78	Yrs. Months Days Hours	Min. 12/14/19	26 New York
		Usual Residence of Decedent				10d Isside City Lin
show	_	10a. State 10b. County Maryland Wicomi		, Town or Location Llisbury		10d. Inside City Lim 1 ☐ Yes 2 🔀
38-f	ecto	2		10f. Zip Code	100	. Citizen of What Country?
B or 2	吉	10e. Street and Number 8432 Hilda Driv	7 <u>0</u>	21804	109	USA
ene. than "natural", or Items 23e or 28e-f show he Medical Exert a at mast be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S		? (Specify Yes or No-	14. Race - American Indian,
r lter	Fun	1 ☐ Never Married 2 X Married	Armed Forces? 1 XYes 2 □ No		uerto Hican, etc.)	Black, White, etc. Specify: White
Pal',	ğ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: Army			Specify: WILLE
natu	Completed	15. Decedent's E (Specify only highest g	ducation rade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	f working 16	b. Kind of Business/Industry
than the Me	ldm	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Business Consultant		Consulting
Hygie ther t	ပိ	17. Father's Name (First, Middle, Las			Name (First, Middle, Ma	
ed of	To Be	Nathan Satloff	•	Edna	Belkin	
artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28e-f show injury or other traumatic event, the Medical Evar diet mat be rediffed at	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and Number of	or Rural Route Number, C	City or Town, State, Zip Code)
27 is		Josephine Satlof	f/wife	8432 Hilda Dr., Sal	isbury, MD 2	21804
of Health f item 27 r other tr		20a. Method of Disposition	rie n	ace of Disposition (Name of emetery, crematory or other place)	Date 20	c. Location - City or Town, State
int: If		1 ☐ Burial 2 【XCremation 3 `4 ☐ Donation 5 ☐ Other (Spec		isbury Crematory 6/	10/05 Sa	alisbury, MD
Department of Important: If any injury or once.		27. Signature of Funeral Service Lice	ensee	22. Name and Address of Facility	1 Home Profe	essional Association
Per Suny Suny Suny Suny Suny Suny Suny Suny		Nous of Non	poor CFSP	501 Snow Hill R	d., Salisbu	ry, MD 21804
ysician and burial-transit	I Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) C. Due to (or as a consequence)	The Local Control of	lure	
ys se	Ilcal		d			
by the attending phy lached for use as th	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ed by detac	y Ph	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death
ig eq		Cerebrovas	cula disea	0.0	1 ☐ Yes	2 No 3 Probably 4 Unkn
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te has been s age 2 should	ompleted	Cerebrovasco				d2 death? No 1 ☐ Yes 2 ☐ No
	O	25. Was case referred to medical		26. Place o		No 1 ☐ Yes 2 ☐ No
	o Be C	25. Was case referred to medical examiner?		ER/Outpatient 3 DOA Other: 4 Nurs	1 ☐ Yes f Death (Check only one) ing Home 5 ☐ Residen	No 1 Yes 2 No Ce 6 Other (Specify)
this certificate has been sral director, page 2 should	To Be C	examiner?	Hospital: 1 Lapatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA Other: 4 Nurs 28b. Time of Injury 28c. Injury at Work?	1 ☐ Yes f Death (Check only one) ing Home 5 ☐ Residen 28d. Describe how	No 1 Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene Reg. No 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Schelle Alfred 2005 23 6:35 A. June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Coffman Nursing Home Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Sept • 2 9. Birthplace (State or Foreign **Funeral** 1 M 2 ☐ F 212-14-6482 85 Sept. Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at MD. Washington 1 ☐ Yes 2 X No Director Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 14052 Village Mill Dr. 236 21767 U.S.A. death v Funerai Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 💢 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry t of Health and Mental Hyglene. If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Construction Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Schelle Virginia Schenbeck Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida M. Schelle /Wife 14052 Village Mill Dr.-P.O Box 393 Maugansville Md. 21767 or other 20b. Place of Disposition (Name of cometery, cromatory or other place)
Cedar Grove Memonite 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) Department of Important: If any Injury or once. 6/27/05 Greencastle, Pa. Church Cemetery

22 Name and Address of Facility
Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licensee lader 45 S. Carlisle St. Greencastle, Pa. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) etre peritere **Physician** LA /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of burial-tran Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 ☐ Yes 2 ☐ No 3 Probably been s 24b. Were autopsy findings available prior to completion of cause of death? s certificete has b director, page 2 s 24a. Was an autopsy performed? 2 2 NO 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification; To 4 Tursing Home 5 Residence 6 Other (Specify) To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner 4 th ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3661 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 - SAMUEL CHAN M.D Antietam St 31. Date filed (Month GN Yar)8 2005 State Registrar

			For State Registrar	State of Maryland /		artment of H		Mental Hy	rgiene 005	21478
	Dharais		1. Decedent's Name (First, Middle, L	ast)				2. Date of De	eath	3. Time of Death
	Physici /Medi		Glendora Mae	Stevenson				June	Day Yea	7.00 AM
	Examir		4a. Facility Name (If not institution, g.			4b. City, Town, or	Location of Dea		4c. County of De	
			328 North Loca	ust St.		На	gerstow of Under 24 Hr	n	Washingt	on County
	Funeral			Sex 7. Age (In yrs. last t	Yrs.	If Under 1 Year Months Days	Hours Min		th ay, Year) 9.8	on County irthplace (State or Foreign Country)
	Director		215-42-3076 Usual Residence of Decedent	62	113.			Nov. 2	4 1942 M	aryland
	yland		10a. State 10b. County	10c. City, To	wn or Lo	cation	*			10d. Inside City Limits
	a-fe	ctor	Maryland Washir	ngton	Hage	erstown				Yas 2 No
	ih th	Oire.	10e. Street and Number	J	-1129	10f. Zip Code			10g. Citizen of What	Country?
	ath w	rai	328 North Loca			2174			United Sta	ates
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23e or 28e-f ehow other traumatic event, the Medical Examinar must be indiffied at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (: n, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
36	urs aft	by	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	□Yes ≱ No	Specify:		Specify:	White
21215-0036	2 hou	ted	15. Decedent's I	Education 16	a. Deced	ent's Usual Occupa	ation		16b. Kind of Busines	s/Industry
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	filed withi Hygiene. other than	5	10		Ho	usekeeper			Commission	n on Aging
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Maryland	should be nd Mental marked o	2	Charles Avery Bis						zabeth Shar	
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	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my knowledgeminer: On the basis of examination a	ge, death ind/or inv	occurred at the time estigation, in my op	e, date and place inion, death occi	a, and due to the ourred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	ithin 2	Med	29b. Signature and title of certifier	and mariner stated.		200 Linner			29d. Date signed (Mon	
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7			30. Name and address of person who	completed cause of death (Item 23a)		Print)	-1-1		0/17	~ J
5			LOUVE & ASher M	D all of Walant	4	LAUR	A B. ASHEF BA 840604	M.D. Ha	6/141 cgerstown	MD 21740
	Sta		31. Date filed (Month Pay Year)	2005 32. 9 gistrar's Signature					<u> </u>	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2005 9:00 AM Lynn Eugene Stoner June 13 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 21514 Mt. Aetna Road Washington County Hagerstown 5 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 1 1951 Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs Director 219-54-0316 53 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐Yes Ž\☐No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21514 Mt. Aetna Road 21742 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Lineman Power Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bernard Stoner Hilda Wishard other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicky L. Stoner 21514 Mt. Aetna Road Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page. Department o Important: If i any injury or once. Broadfording Ch. Cem. June 17 05 Hagerstown Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final **Physician** ance 2 minth's disease or condition resulting in death) /Medical Due to (or as a consequer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1₽Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 1No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check and mariner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Viellain 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 151 11110 medical Campus Rd Hagerstown 17 Kass Frederic 31. Date filed (Month Day Year) 2005 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elsie June Slonaker 2005 June 9, 12:30 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Yrs. Director 215-28-3944 Sep 13, 73 1931 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland woys 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2∑ No Carroll Hampstead Funeral Directo Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1318 Hillcrest Street 21074 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 25 Married 1 ☐ Yes 2 ☑ No Specify: white Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home nd 2 should be filed alth and Mental Hygic 27 is marked other reteumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked of any injury or other treumatic even 20168. Mary Elizabeth Bleach George Grafton Dietz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence J. Slonaker, husband 1318 Hillcrest Street, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead Cemetery 06/13/2005 Hampstead, MD 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Farieral Service Licensee Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTICAEMIC SHOCK POSSIBLE **Physician** /Medical Due to (or as a consequence of): Examiner PHERMONIA SECONDARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed KLEBSIELLA PSEUDOMONGAS AICALIGENES, Due to (or as a consequence of): burialattending physician Physician/Medicai as the t IF FEMALE use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS NON 1 Yes 2 No 3 Probably 4 Unknown Be Completed CHRONIC OBSTRUCTIVE LUNG 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has CORONARY ARTERY DISEASE certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3□ DOA his After this funeral d Manner of Death
Natural
Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending 5 Pending 1 Tes 2 No hours after death. investigation within 24 hours after death To the Funerel Director:.. completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 025052 MJ OWINGS MILLS MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAFEEZ SYED 20 CROSS ROADS DRIVE 32. Registar's Signature 31. Date filed (Month, Day, Year) lean & speck 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

		1 - For State Registrar	State of Maryland			t of H	ealth a	nd Me	ental Hy	Reg. No.	00	5 2	21481
Physic /Medi	ical	Decedent's Name (First, Middle, Last) Sterlin Ear Aa. Facility Name (If not institution, give steel)	hart Tavel	Jr	4h City	Town or	Location of	J	2. Date of De Month une	Bay	200 County of I		3. Time of Death 12:45 A M
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h with the 23a or 28a st be notif	al Direc	10e. Street and Number 9528 DuBarry Ave	nue		10f. Zip	Code 10706				-	zen of Wha		/?
In yially 2 12 12 15 15 15 15 15 15 15 15 15 15 15 15 15	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Amed Forces? PUTYes 2 □ No 1944 If Yes, Give Year or Dates: 194	-	Was Dece If Yes, spe 1 Yes		spanic Origin, Mexican, Specify:	in? (Spec Puerto F	cify Yes or Ni lican, etc.)	0-	14. Race Black, \ Specify:	Americar White, et	o
within 72 ho ene. than "natur	ompleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1.2	cation e completed) College (1-4or 5+)	life.	kind of wo DO NOT u	rk done d se retired	turina most i				nd of Busin		_{stry} tric Powe
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			State of State Amend Item 28b per m	ie G845	7-6-0	tas rtificate of Dea	ath	Reg. N2 0	05 21482
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	/Medi		Barbara L. Thompson				June	10	2005 10:20 A ^M
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:	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the b 2 Medicel Exeminer: On the bas	is of examinati	vledge, death ion and/or inv	occurred at the time, date restigation, in my opinion, o	e and place, and due to the death occurred at the time	cause(s) and m	nanner as stated. , and due to the cause(s)
:	To the within 2 To the complet	Med	29b. Signature and title of certifier	StateO.		29c. License numb			ed (Month, Day, Year)
, '	F S F Ö		MOLINERO DAO CHA	02	14.	OCME			
^	OF		30. Name and address of person who completed cause	of death (Item	23a) (Type. I	Print 11 D C	tweet P-14-1		1, 2005
(KD		MARGARITA B. KURE	u		III Penn S	rreet paiti	more, Ma	aryland 21201
	Sta	_		jistrar's Sig <i>na</i> tu	штө	-0			
	Registr	dľ	JUN 1 4 2005		Conse				

State of Maryland / Department of Health and Mental Hygiene

				Glate of W	arylai		•		f Death	Wichtai 11	Reg. No.?)	105	0:	1.00
	5 1		1. Decedent's Name (First, Middle,	Last)						2. Date of D Month		Year	Time	64 Death
	Physici /Medic	_	GILBERT TREN	T						June	Day 9	2005	4:53	3 AM
4	Examin		4a Facility Name (If not Institution,						4b. City, Town, or			ty of Death		
			Washington Adven				/ If I Inc	er 1 Yea	Takoma			ntgome		
	Funeral Director		228-44-5741	. Sex 7. Ag 1∭0 M 2□ F	ge (In yrs.	S Yr	Month			Dec.	irth Pay, Year) 6, 1938	9. Birthp	viace (State	e or Foreign
	end **	ł	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town o	or Location					1	0d. Inside	City Limits
	Menylen -f show	호	District of Colu	mbia			Was	shin	gton				1 ሺ Ye	es 2□No
	or 28a-f	l'ec	10e. Street and Number		1		1	ip Code			10g. Citizen o	f What Cour	ntry?	
	th will	a	3414 Croffut Pla						20019			USA		
020	filed within 72 hours efter death with the Merylend Hygiene. ther then "natural", or items 23a or 28a-f show ant, I've Medicel Examiner must be nothined at	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1	Ever in U No 1	,s. .956			Hispanic Origin? (Suban, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	o- 14. R			
5-0	72 hours "natural", adical Ex	etec	15. Decedent's (Specify only highest)	Education grade completed)		16a. D	ecedent's Us Give kind of v	ual Occ	upation e during most of wo red)	rking	16b. Kind of	Business/In	dustry	
121	vithin hen	m	Elementary/Secondary (0-12)	College (1-4or	5+)	1						Privat	- 0	
2	iled v Hygie thar t	ပ္ပ	17. Father's Name (First, Middle, La	st)		Su	ustano	e A	buse Coun:				.е	
an	d be i	e e	Unknown						Violet					
۳	shoul nd Me mark imati	۵	19a. Informant's Name/Relationship Peggy O. Sandife	(Type, Print)		19b. N	failing Addre	ss (Stre	et and Number or Ri			n, State, Zip	Code)	
Ž	nd 2		Peggy O. Sandife	r Signif: Other	icant	341	4 Crof	fut	Place, Si	E Wash	ington.	DC 2	20019	
J.e.	ss 1 e of Hea item		20a. Method of Disposition		20b. F	Place of D	isposition (A crematory of	ame of other p	/ace)	Date	20c. Location			
Ē	Page nent c int: if		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				n Memo			6/17/05	Su	itlan	d, MD)
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 7: Department of Health end Mentel Hygiene. Important: if item 27 is marked other then "ne any injury or other traumatic event, the Medions.		21. Signature of Funeral Service Lic	ensee					ress of Facility Joing Road,	ordan Fu				
		\neg	23a. Part1. Enter the disease of co shock, or heart failure. List or	mplications that cause	d the deat	h. Do not	enter the m	ode of d	ying, such as cardia	c or respiratory	arrest,	11, 1/0	Approxim Interval B	
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hyper	ka1er	nia	nsequence o						Onset and	d Death
	bei ist	ie		■ b. End S			1 Dis							
_60	wecut and al-trar	xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (d	ras a cor	nsequence o	f):				i		
68760,	siciar bouri	Sai	that initiated events	c	Due to /o	7 26 2 005	sequence o	n ·						
-	certificate be executed ding physician and se es the burial-transit	/Medicai Examiner	resulting in death) Last	d		43 4 001	1304001100	··				į		
Bo	es that the death cer igned by the attendir be deteched for use	ciar	D-11 On-1-1 -10-1						river in Brend I	agh Die	tobacco use o	antributa t	the cour	o of death?
P.0.	the d by the echec	hysi	Part II. Other significant conditions	contributing to death t	out not res	uiting in tr	ne underi y ing	cause	given in Part I.		Yes 2 🗓 No			
σ,	s that	Ž									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Division of Vital Records,	sw requir s been s 2 should	Medical Certification: To Be Completed by Physician/								24a. Wa perl	s an autopsy formed?	av	ere autops ailable prio mpletion of death?	or to
Ä	The law ate has page 2:	ĕ								10	Yes 2 No	10]Yes 2	□ No
/ita	sien: ertifica actor,	Be (25. Was case referred to medical examiner?						26. Place of De	ath (Check only	one)			
)t	hysic his co	P	1 Yes 2 No	Hospital: 1 ☐ Inpati			atient 3 1	JUA		forme 5 ☐ Res			y)	
n o	ing P	<u>ö</u>	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Tim Inju		28c. Inj	uryat lork? □Yes 2□No	28d. Describe	how injury occ	urred		
isio	death death stor: /	Cat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be an Bloom of In	iurv - Ath	ome farm				28f. Location	(Street and Nur	nber or Rura	I Route No	umber.
Ω	E E E	Certif	4 ☐ Homicide determine	building, et	c. (Specif	y)	, 30000, 1000), Oilo		City or To	wn, State)			
	Hospital 24 hours Funaral etely filled	dicai		Phyaician: To the best aminer: On the basis of and manner st	f examina									B(S)
	within 2 To the comple	Me	29b. Signature and title of certifier	-11 2/ 1	1 .		2	9c. Lice	nse number		29d. Date sign	ned (Month,	Day, Year))
	0	a	James K	Tuft of	h., 1	1-V.		52	326		June	9.	2005	5
	(1)101	t	30. Name and address of person wh	o completed cause of	death (Iten	n 23a) (Ty	/pe, Print)				2091			
	2C		James K. Ligh	tfoot, Jr	. N	1.D.	760	0C	arroll A	lvenue	Tako	ma Pa	rk,	MD
	Sta Registr	_	31. Date filed (Month, Day Year)	32. Registr	rar's Signa	ture							-	

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Americal Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar		State of Ma		Certi	ficate of			Reg. No		21484
	Physici	an	1. Decedent's Name	(First, Middle, Last)	Pearl	Norma	Wiat	er TER		2. Date of De Month 06	Day	2005	3:10 A M
5	/Medio			not institution, give s					r Location of Deat		23	County of Death	1
	Examir	er		HEALTH OF		HILL		FOREST		.,	10.	HARFORD	4 1
	Funeral		5. Social Security N	umber 6. Sex	7. Ag	e (In yrs. last		f Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th Vear		place (State or Foreign intry)
	Director		066-12-	(2)(7)	M 2 X F	85	Yrs.	Days	Tiours ivini.	3/23	/192	20 New	York
	and w		Usual Residence of 10a. State	Decedent 10b. County	-	10c. City, To	wn or Local	ion					10d. Inside City Limits
	Maryl f sho	ţ	MD.	Harfo	ord			Fo	rest H	ill			1 Yes 2 No
	r 28e	Director	10e. Street and Nur					10f. Zip Code			10g. Citi	zen of What Cou	intry?
	23e o		1630 M	ichelle	Court	Apt.	D		21050		Uni	ited St	tates
21215-0036	within 72 hours after death with the Maryland ane. than "naturel", or items 23e or 28e-1 show fre M. Jical Examinum, ust be motified at	by Funerai	11. Marital Status 1 Never Marri 3 Widowed	ed 2 Married	2. Was Decedent Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. No	1	s Decedent of Hes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	-	14. Race - Amer Black, White Specify:	
2-0	"nature	Completed	(Snec	15. Decedent's Educ ify only highest grade	ation completed)	16	Sa. Deceden	t's Usual Occup	nation	dring	16b. Ki	nd of Business/li	ndustry
21	ithin 7	npie	Elementary/Seco		College (1-4or 5	i+)	life. DO		during most of wo	ining			
121	TI TO be seen		12 17. Father's Name	First Middle (25t)	0			Homema		me (First, Middle	Maidan	Home	9
Maryland	ed la la) Be	Lear	Burrou	ghs	ጥልን	roox		Vivia		Pear		Cross
Z.	₹ D E E	은		me/Relationship (Typ				Address (Street					p Code) 21028
	d d d d d d d d d d d d d d d d d d d		Jan Wia	ter /Sor	1	2	2613	Palmyr	a Driv	e Chi	ırch	ville,	Md.
ore	ges 1 an t of Heal If item 2 or other		20a. Method of Disp	osition Cremation 3 Re	emoval from State	ceme	tery, cremat	on (Name of ory or other plac		Date		cation - City or T	
ij	Pag nent ant:		° 4 □ Donation	5 Other (Specify)	01	High							Maryland
Baltimore,	permit. Pag Department Importent: any injury o		DY []	nera Sa vide Licend	m Ku	of it	E.	G. Kur	tz & S	on Fund	eral		
			shock, or hea	ne disease, or complic t failure. List only on	e cause in a caused e cause in sech li	ther death. D	o not enter		/ ?	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		Duda la	a consequence	eu (inta	ction			-	der
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list co if any, leading to in Cause (Disease or that initiated events resulting in death) I	nditions, being be		a consequence		Cerdi	orașculi	- Pised	215		0 zees
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 26 9 Unknown	months?	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		topic pregnancy	/			23d. Date of deliv Month	very Day Year
s, p	quires that n signed b	by	Part II. Other signif	icant conditions con	tributing to death b	ut not resulting	g in the unde	orlying cause giv	ren in Part I.		obacco u Yes 2{		the cause of death?
Record	aw requis peen	Completed	Cerel	er Vaseur	la Vi	seecs,				24a. Was		24b. Were aut	opsy findings available ompletion of cause of
Ä	The lay	mo.					е.				rmed?	death?	
Vital	ilcien: Th certificate rector, pag	Be	25. Was case refer examiner?	1					26. Place of De	ath (Check only o			
of V	Physicien: rthis certific ral director.	은	1 Yes 2	140	ospital: 1 Inpatie		Outpatient	3 DOA Oth	Nursing F	lome 5 ☐ Resi			ify)
ou c		tion:	27. Manner of Deat Natural	5 Pending investigation	28a. Date of Inju (Month, Da	y Year) 28b	. Time of Injury	28c. Injur Wor M 1 🗀	yat k? Yes 2 ⊟No	28d. Describe	how injur	y occurred	
Division	Atten deat ctor: y the	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Płace of Inj building, et	ury - At home, c. (Specify)	farm, street		100 2010	28f. Location (. City or To	Street an wn, State	d Number or Rui)	ral Route Number,
	To the Hospitel or I within 24 hours after To the Funerel Dire completely filled in D	Medical (29a. Certifier (Check only one)	Certifying Phys	ician: To the best er: On the basis o and manner st	examination	ge, death or and/or inves	ccurred at the tir tigation, in my o	me, date and place	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(ŝ)
	To t	Σ	29b. Signature and	title of Contifier				29c. Licens			29d. Dat	e signed (Month	Day, Year)
			4//	M	A Po	FAC	P	H59	7022		Jun	2232	005
_			DR PET	ER LOPREST	O G T	1308			ER WAY,	EDGEWOOI), MI	21040	
	Sta Regist		31. Date filed (Mon	JUN 2 9 20	05 32. gistr	ar's Signature	1	77					

			1 - For State Registrar	State of N	Marylan				lealth a		ental Hy	/giene Reg. Nef		\ r-	011.5
	Physic		Decedent's Name (First, Middle, I Evelyn Tu	,	White						2. Date of Do Month	eath Day	Ut	Year	1800 M
?	/Medi Examir		4a. Facility Name (If not institution, g	ive street and numbe	r)		4b. City	, Town, or	Location	of Death	June 9	,		of Death	
	<u>* * rit</u>		ATLANTIC GENERA			1-11-14-1		RLIN or 1 Year	li I la das	04 Usa				STER	
	Funeral Director		5. Social Security Number 216–38–9282 Usual Residence of Decedent	Sex 7. A 1 □ M 2 🔀 F	90	last birthday) Yrs.	Months		If Under Hours	Min.	8. Date of Bi (Month, Di April	12,1	915	Cour	lace (State or Foreign try) yland
	yland		10a. State 10b. County			ty, Town or Lo								1	0d. Inside City Limits
	8e-fs	Director	Maryland Wicom	ico 		Salish									1 ☐ Yes 2 🔀 No
	with the	Dire	10e. Street and Number 1125 Riverside	Drive				p Code 21801				-	zen of W USA	/hat Cour	ntry?
	ems 2	Funeral	11. Marital Status	12. Was Deceder Armed Forces			Was Dece	edent of H	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	0-		- Amend	an Indian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or items 23c or 28e-f show ant, it is Medical Exact accruist to rediffed at	b	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced		₹No	i	1 □ Yes		Specify:	, , , , , , ,				whi	
15-0	n 72 h "natu edical	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Dece (Give	dent's Usu kind of we	al Occupa ork done o	ation during mos	t of worki	ng	16b. Ki	nd of Bu	siness/Inc	dustry
212	d withi	omo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		makei		,			I	Dome	stic	
Maryland	d tal	To Be C	17. Father's Name (First, Middle, La Ernest Turner	st)		-					(First, Middle Chatham		Sumamı	9)	
	and 2 should ealth and Men n 27 is marke er treumetic		19a. Informant's Name/Relationship Gail Lubeley/da								Route Numb				
Baltimore,	jes 1 and 2 of Health If item 27 i		20a. Method of Disposition 1	□ Bemoval from Stat	1 6	Place of Dispo cemetery, crei	sition (Na natory or	me of other plac	e)	D	ate	20c. Lo	cation - (City or To	wn, State
Ē	tment of the result of the res		'4 □ Donation 5 □ Other (Spec	city)		sons C				6/13				ury,	
Ba	permit. Pages 'Department of H Importent: If ite any injury or ot		21. Signature of Funeral Solvice Lic	on dF	58	5	<u>01 Sr</u>	JOW H	TIT	₹d.,_	Salisb	ury,	iona MD	1 Ass 21804	sociation
	Prrysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	n blications that cause by one cause on each a Due to (or a	ol ol	struc	er the mod	de of dyin	g, such as	cardiac o	r respiratory a	irrest,			Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury	b. Due to (or a	s a conseq	uence of):									
8760,	cate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):									
.O. Box 6	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 🗆 Feta	Ideath 3	Ectopic p					2	23d. Date Mon	of delive	ry Day Year
s, D	uires that i signed b	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying (cause give	en in Part I.		23e. Did t				e cause of death?
Record	aw requir is been si 2 should	Completed						-			24a. Was		24b. W	ere autor	osy findings available
		Com									auto perfo	psy ormed? 2 No	i de	eath?	npletion of cause of
Vita	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hassitali /	<u> </u>					of Death	(Check only o		1		
of	Phys this ral du	-To	1 Yes 2 No	Hospital: 1 Inpat	-	ER/Outpatien	-	Othe 28c. Injury	4 110		ne 5 Resi)
O	Attending Ph r death. ector: After th by the funeral	tlon	1 atural 5 Pending 2 Accident investigat	(Month, D	ay Year)	Injury	м	Work	(? Yes 2 ⊡i		8d. Describe	now injury	CCCUITE	rd .	
Division of	or Attendatter deatt Director:	Certification;	3 Suicide 6 Could not determine	d 286. Place of II	njury - At ho etc. <i>(Specif</i>	ome, farm, str	eet, factor	y, office		2	8f. Location (City or To	Street and wn, State)	d Numbe	r or Rura	Route Number,
	To the Hospitel or Attenwithin 24 hours after dealt To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one)	in sician: To the bes aminer: On the basis and manner s	of examina	wiedge, death tion and/or inv	occurred vestigation	at the time, in my op	e, date an pinion, dea	d place, a	nd due to the	cause(s) date and	and man place, a	ner as stand due to	ated. the cause(s)
	To the within To the Complex c	Me	29b. Signature and title of certifier					c. License				29d. Date	signed	(Month, L	Day, Year)
	32.		· Mu	mo					612			6	19/8	25	
	The state of the s			o completed cause of		33 (Type.,	Print) ealt	Lue	us D	V 13	portin	n	(1)	218	11
	Sta Registr		31. Date filed (Month, Par Near) 3		trar's Signa	ture	2	0.	U		-	,			

21/21/4 200 18cp -88-718

White, Evelyn T.

		1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath	. 0.0.6	6.71	O OF THE
Physicia		Kenneth Deryl	•						Month	Day 20	Year 20	.r 3	17:38
/Medica Examine		4a. Facility Name (If not institution,		er)	4b. City,	Town, or L	Location o	of Death	<u>June</u>		∠U County of De		17:30
		20602 Rodeo	o Drive		Вос	onsbo:	ro				Vashin		
Funeral		5. Social Security Number 6	5. Sex 7. 1 X M 2□F	Age (In yrs. last birth	Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of B	irth	0.8	Sirthplace (Sta	ate or Fore
Director	-	462–13–1179 Usual Residence of Decedent	IAIM ZLIF	42 Y	rs.				Jan 6	5,1963	ì	Texas	
Mot		10a. State 10b. County		10c. City, Town	or Location							10d. Insid	le City Lin
28e-f show	ctor	Maryladn Washi	.ngton		Boonsbo	ro						10	Yes 2█
or 28	Director	10e. Street and Number			10f. Zip	Code				10g. Citize	en of What (Country?	
s 238		20602 Rodeo Dr			10.111	2171						States	
ital hygiene. Id other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceded Armed Force d 1 Tes 2 If Yes, Give Year or Date	∍s? ≦ No	13. Was Deced If Yes, spec		, Mexican Specify:	gin? (Spe , Puerto	ecity Yes or N Rican, etc.)		1. Hace - An Black, Wh Specify: ₩		٦,
atura cel E	ted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of working the first complete (Give kind of work done during most of work done					16b. Kind	d of Busines	ss/Industry				
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ygien her th	S	11			Co-Ow							tion C	0.
and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last) 18. Mother's Nam									en Sumame)		
and Mental I	ပ	James Robert W 19a. Informant's Name/Relationship		19h J	Mailing Address	(Street an		_	a Jear				
27 is 27 is r trau	ĺ	Lucinda M. Will		10.00								20000000	
it of Health and Men If Item 27 is marke or other traumatic	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from Sta	20b. Place of I cemetery	U602 30 Disposition (Name, crematory or of	ne of ther place))	D	ate	20c. Loca	ation - City o	or Town, State	
Department important: It any injury o	-	'4 □ Donation 5 □ Other (Spe21. Signature of Funeral Service Lice		Smiths	burg Cr								•
impo any ir once		11110/2	1, 7					DOL	_		_	neral H	
				11 .	1771 77							7 7	047
	-	23a. Part1. Enter the disease, or co	omplications that cau	sed the death. Do no	1331 E	<u>aster</u> e of dying,	such as	cardiac o	r respiratory	ersto arrest,	wn Mar	cyland Approxim	mate
vsician	1	Immediate Cause (Final	ny one cause on each	n line.	ot enter the mode	e of dying,	such as	cardiac o	r respiratory	arrest,		Approxim	mate Between
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrat 21487 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month June 10, 2005 Martin White 11:35 Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27837 Waller Road Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠** M 2 ☐ F 69 Yrs. Director 220-32-9470 1/29/1936 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show s 23a or 28e-f show 1 ☐ Yes 2 X No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27837 Waller Road 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Marine or itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ģ Specify 3 ☐ Widowed 4 ☐ Divorced white "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant. It seems Elementary/Secondary (0-12) College (1-4or 5+) construction Supervisor Highway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer White Agusta Belle Malone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia White/wife 27837 Waller Rd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Stevensville Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 6/15/05 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cend Physician /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a con-Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 3 Probably 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: of or Attanding F after death. Director: After After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and certifier 29c. License number 29d. Date signed (Month, Day, Year) HSYEZ7 impleted cause of death (Item 23a) (Type, Print) Ste 103 Helman 31. Date filed (Month, Day, Year) State JUN 1 5 2005 Registrar

		For State Registrar	State of Ma		artment of H		Mental Hygie	0020	5 21488
Physici /Medi		Decedent's Name (First, Middle, La Nancy Lee Wa	l.ton		,		2. Date of Death Month June 9,	2005	3. Time of Death 2245 M
Examir	ner	4a. Facility Name (If not institution, giv Carroll Hospita			4b. City, Town, or Wes	r Location of Dea Stminste		4c. County of	Death Carroll
Funeral Director		219-34-1274	Gex 7. Age I□M 2ਊF	e (In yrs. last birthday 66 Yrs.	Months Days	If Under 24 Hrs Hours Min		ear) 1938	9. Birthplace (State or Foreign Country) Maryland
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Bal	timore	10c. City, Town or L		Reisters	stown		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the 3e or 28a	Funeral Director	10e. Street and Number 14605 Old Hanov	er Road		10f. Zip Code	21136		. Citizen of Wh	nat Country?
s after death	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (San, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23e or 28e-f show says injury or other treumatic event, the Medical Examina crisist by notified at once.	Completed t	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give	edent's Usual Occup e kind of work done o DO NOT use retired HOMEMA	during most of wo i)	rking 16	b. Kind of Busi Own	
Idio Called w lental Hygier ked other ti	To Be Cor	17. Father's Name (First, Middle, Last, Herbert E. Couc	_		notiens	18. Mother's Na	me (First, Middle, Ma la J. Gove	iden Sumame)	
, IVICILY and 2 show salth and M n 27 is mar er treumat	-	19a. Informant's Name/Relationship (ural Route Number, C Taneytown,		
Peges 1 and nent of Health nt: If item 27 rry or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			osition (Name of matory or other place to Grove Ce				ity or Town, State
permit. Department imports any injuit.		21. Signature Juneral Service Licer	MY d	723 · 2	2. Name and Addres		Eline Fur t, Hampste		
Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	the death. Do not en	1	g, such as cardia		Jense	Approximate Interval Between Onset and Death
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el or Atten s after dea el Director ed in by the	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 200 Place of Inju	ıry - At home, farm, st :. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S		or Rural Route Number,
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edicai	(Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	th occurred at the time	ne, date and place pinion, death occ	e, and due to the caus urred at the time, date	e(s) and mann and place, and	er as stated. If due to the cause(s)
P S P P P P P P P P P P P P P P P P P P	Σ	29b. Signature and title of certifier	Trene	ens 4	> Poc		ŧ .		Month, Day, Year) 10, 2005
h3,11			INGERUSE	WD	Print) 200 ME		WES MI	NO	(MO 7112)
Sta Registi		31. Date filed (Month, Day, Year) JUN 1 4	32. Registra	r's Signature	book				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2005 Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** C. Yates June 12, 2005 11:40 P Cora /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Riverdale Prince George's Genesis Cresent City Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Jan. 11, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Washington, DC 1 □ M XX F 579-36-4970 77 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Items 23s or 28a-f show 1 ☐ Yes 2xx No Director Prince Georges Maryland Springdale 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 20774 3807 92nd Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status traumatic avent, the Mudical Examiners filed within 72 hours after 1 Yes XX No
If Yes, Give
Year or Dates: 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 ö 1 Yes 2XXNo Specify: Specify: Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) 2 years Private School Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leona B. Washington John Chamberlain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Claudia Yates-Timmons / Daughter 3807 92nd Avenue Springdale, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 18,2005 Clinton, Maryland Resurrection Cemetery 21. Signatural Funeral Service 22. Name and Address of Facility P. Kalas Funeral Home P.A. elis 6160 Oxon Hill Road Oxon Hill Marrland Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Condiovascular Immediate Cause (Final USINO lei **Physician** disease or condition resulting in death) /Medical Due to (or all a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2√x No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 🗓 🛣 o Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funaral C 29a. Certifier **Exxertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 06-13-2005. 48213 completed cause of death (Item 23a) (Type, Print) YIE Ave Landovertills MD 20784. 4410 Ashou N.D reolam 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 1 5 2005

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month GORDON ALEXANDER 11:10P M June_ 28, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HOSPICE OF BALTIMORE AT GILCHRIST CENTER IFR Towson
If Under 1 Year If Under 24 Hrs. Baltimore County

9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1\ M 2□ F Months Days Hours 92 Director 074-09-7879 July 22, 1912 Scotland, U.K. Usual Residence of Decedent ir than "natural", or Itams 23a or 28a-f show The Medical Evaninar must be multipud at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Baltimore County Maryland 1 ☐ Yes 2 → No Director Towson the ! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Thornwood Court 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Manager 12th and Mental Hygie is marked other t Canning Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be d 2 should be fit and Mental It Robert Shearer Gordon 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health an Important: If item 27 is n. any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice R. Alexander (Wife) 706 Thornwood Court, Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 7/5/2005 Baltimore, Maryland 21. Signardh of European Saxykal icohsee

Martin D. Lawson Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

6500 York Road, Raltimore Maryland

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter ne moled ying, such as car lac or respiratory artes.

21212

Approximate Interval Between Onset and Death

Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to for as a consequence of) jears /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 A ther (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Aatural Injury after death. 1 ∏ Yes 2 □ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To tha Funeral I 29a, Certifier 😭 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 29 2008 28303 who completed cause of death (Item 23a) (Type, Print) 10 msm, us 2120c wo 6601N. Charles 3 0 2005 32. registrar's Signature State

Registrar

αI			1 - State Unpend Item	State of Ma 23a&27 per	aryland/De c me G845	partment of l	lealth and Death		giene Reg. No 200	5 211.01
	Physic	ian	1. Decedent's Name (First, Middle,	Last)				2. Date of De		3. Time of Death
>	/Medi Exami	cal	4a. Facility Name (If not institution, g	an Brock		4b. City, Town, o	r Location of De	June 28	3, 2005 4c. County of D	4:15 P M
	LXaiiii	lei	4114 # 3 Flint		1	Darling		batti	Harford	
8	Funeral Director		5. Social Security Number 6 220-50-0373	Sex 7. Ag 1XM 2□F	e (In yrs. last birtho 47 Yrs	(ay) If Under 1 Year Months Days	If Under 24 h	Hrs. 8 Date of Birt (Month, Da SEP 9,	h 0	Birthplace (State or Foreign Country) Maryland
5	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location			1001	
	Marylan -f ehow iled at	tor	Maryland Hari	ord	roo. Oily, rount o		ngton			10d. Inside City Limits 1 ☐ Yes 2 📉 No
	ith the M or 28a-f	Director	10e. Street and Number	OLG		10f. Zip Code	ngton		10g. Citizen of What	Country?
	s 23a			ntville Roa			21034		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene Itiam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, I'm Medical Evantian must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
2-0(72 hours "natural",		15. Decedent's (Specify only highest of	Education	16a. De	ecedent's Usual Occup	ation		16b. Kind of Busine	
Maryland 21215-0036	12 should be filled within hand Mental Hygiene. 7 is marked othar than "traumatic event, the Ne	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	ive kind of work done e. DO NOT use retired TPenter	during most of v	working	C	
nd 2	al Hyg I othar Vent, I	Be C	17. Father's Name (First, Middle, La	,	Ca.	rpenter	18. Mother's N	Name (First, Middle,	Construc Maiden Surmame)	erion
ylaı	ould b Menta	To	Johnnie Allen						arie Hull	
Mar	id 2 sh th and th s m 17 is m traum		19a. Informant's Name/Relationship Patricia A. Deck			ailing Address (Street				
Ē,	s 1 an of Heal itam 2 other		20a. Method of Disposition		20b. Place of Dis	207 Carrol sposition (Name of crematory or other place		Road Pho	enix, MD 20c. Location - City	21131 or Town, State
Baltimore,	Page ment c ant: If ury or		1 ☐ Burial 2 ⚠ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	□Removal from State cify)	1	rematory,	Inc. 6	/30/05	Baltimon	e. MD
Balt	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trau		21. Signature of Buneral Service Lic Edward A.	Gregorchik		Cremation 299 Frede	Society Society rick Ro	y of MD,	Inc.	21228
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each lin	the death. Do not	enter the mode of dyin	g, such as card	iac or respiratory arr	est,	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Hyperte Due to (or as a	nsive Car a consequence of):	diovascula	r Disea	ise		Onset and Death
	Examiner	L	Sequentially list conditions,	b						
V	nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	a consequence of):					
o,	an and rrial-tra	Exa	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):					
68760,	cate be chysici the bu	edicai		d						
Box.	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 Live birth 2	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of o	elivery Day Year
P.0	that the di ed by the detached	Phys	9 🗆 Unknown	9□ Unknown						
	w requires that been signed should be det		Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause give	on in Part I.			to the cause of death? Probably 4 Dunknown
Vital Records,		Completed						24a. Was a autops perform	y prior to	
Vita	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	Hospital:		046		eath (Check only on	θ)	
of	ing Ph	ion: To	Yes 2 No 27. Manner of Death 1 Xatural 5 Pending	28a. Date of Injury (Month, Day	28b. Time	of 28c. Injury Work	at ?	Home 5 Reside	ence 6 MOther (Sp ow injury occurred	ecify) scene
Division	tan leat ror: the	Certification:	2 Accident investigation 3 Suicide 6 Could not investigation 4 Homicide determined	00	ry - At home, farm, (Specify)	M 1 1	′es 2□No	28f. Location (St. City or Town	reet and Number or I State)	Rural Route Number,
	Hospital of the spiral of the		29a. Certifier 1 ☐ Certifying P	hysician: To the best of	f my knowledge, de	2th accurred at the time				
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only 2 X Medical Exa	miner: On the basis of and manner stat	examination and/or	investigation, in my op	inion, death occ	ce, and due to the ca curred at the time, da	ate and place, and du	is stated. le to the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	4/001	2 0 01	29c. License		29	9d. Date signed (Mor	oth, Day, Year)
	pend		30. Name, and address of person who	completed cause of de	ath (Itah 22=) CT	9	_	Jı	ine 29, 20	005
-	0,		CAROCHI	TUANIA	ld	111 Penr	n Street	t Baltimo	ore, Maryl	and 21201
l de	Sta Registra		31. Date filed (Month, Day, Year) JUN 3 0 2	32. Tegistrar	_	Coull !				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NO 1 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Year Edith Hamilton Borgmann June 25, 2005 /Medical 7:10pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Charlestown Care Center Catonsville BAltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 F **Director** 218-18-2278 81 Nov. 15, 1923 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County show. 10c. City, Town or Location nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla nartment of Health and Mental Hygiene. ortant: If itam 27 is marked other than "natural", or Itams 23a or 28a-1 shoy injury or other traumatic event, If a Medical Examiner west to multiple at 10d. Inside City Limits Directo 1 Yes XX No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1107 McAdoo Ave. 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24.2No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes XXNo Specify: White white Specify: X3□ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Sales Department stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew JOSEPH Greb Barbara Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail T. Nunn- Daughter 1107 McAdoo Ave. BAltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 6/28/05 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory @ Loudon PArk BAltimore City 22. Name and Address of Facility Loudon PArk Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. BAltimore, Maryland 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician werella disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.0 the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, er ovarular 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Fo tha Hospital or Attending 1 Natural 2 Accident 5 Pending after death.

Diractor: Aft
d in by the fun investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral D PC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10020040 0 deden Chope Cane, Cotourrello 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vary 31. Date filed (Month, Day, Year) 32. Registrary Signature MARINE JUN 3 0 2005 Registrar

			_ State		artment of Health and Martificate of Death		ne	21102
	Physic	an	1. Decedent's Name (First, Middle, Last)	3n = 0 1	runcate of Death	Reg. 2. Date of Death Month	N2 U U 5 Pay - Year	3. Time of Death
?	/Medi Examir	cal	4a, Facility Name (If not institution, give street	and number) Street	4b. City, Town, or Location of Death Pal Himore		4c. County of Death	4. 75AM
	Funeral Director		5. Social Security Number 6. Sex 1 9-12-9416 1 WM 2 Usual Residence of Decedent	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign try)
	with the Maryland a or 28a-f show the notified at	tor	10a. State 10b. County	10c. City, Town or Lo	more		1,	0d. Inside City Limits
	ath with the 23a or 28s ust be nell	ai Director	10e. Street and Number 3933 Frisby S	Hreet	10f. Zip Code 2/2/8	10g.	Citizen of What Coun	try?
5-0036	after des	by Funer	11. Marital Status 12. W. Ar 1 Never Married 2 Married 1	¥Yes 2 □ No	Was Decedent of Hispanic Origin? (Splf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify: Plan	
21215-0	within 72 hours ene. than "naturel", to Medical Ere	Be Completed	15. Decedent's Education (Specify only highest grade com, Elementary Secondary (0-12)	oleted) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Inc	lustry
Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other than eumetic event, the Ms	To Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maid	den Surname)	UC VAJ NAKOS
	s 1 and 2 show if Health and N item 27 is ma other treume		19a Informant's Name/Relationship (Type, Pr	4 (WiFe) 393	ng Address (Street and Number or Rur 3 Frisky St	al Route Number, Cit	ty or Town, State, Zip	Code)
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		isition (Name of matory or other place) A Torest (enclored) And an Aldress of mility	5/05 ²⁰⁰	Location - City or To	wn, State
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not ent	er the mode of dying, such as cardiac	K. R.C. J. or respiratory arrest,	30140.14	D 21212 Approximate Interval Between
1	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	ral fri. Iur			Onset and Death
8760,	ate be executed hysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events c.	Oue to (or as a consequence of): Oue to (or as a consequence of):				
.O. Box 6	The law requires that the death certifics to has been signed by the attending proage 2 should be detached for use as to	Physician/Medical	in the past 12 months?		Ectopic pregnancy		23d. Date of deliver Month	y Day Year
ds, P.	signed b	þ	Part II. Dther significant conditions contributin	ng to death but not resulting in the ur		23e. Did tobacc	o use contribute to the	
Records,	ie law requir has been si je 2 should	Completed	Depention	1	5 47 6	24a. Was an autopsy	24b. Were autop	sy findings available
		Be Con	End - Strail 25. Was case referred to medical examiner?	e renal d		performed: 1 Yes 2	death?	Plates of Galage of
of	Phys this ral dii	2	1 ☐ Yes 2 ☐ No Hospita 27. Manner of Death 28a	Date of Injury 28b. Time of	t 3 DOA Other: 4 Nursing Ho		6 □Other (Specify)	
Division	or Attendin after death. Director: Aft in by the fun	Certification;	2 Accident investigation	(Month, Day Year) Injury Place of Injury - At home, farm, strebuilding, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
Ω	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical Cer	Medical Examiner. Of	To the best of my knowledge, death	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause	(s) and manner so the	ted.
	To the within 2 To the comple	Med	29b. Signature and title of certifier	d manner stated.	29c. License number	29d. [Date signed (Month, D	ay, Year)
	B		30. Name and address of person who complete		Print)		30/01	ž
	Sta	te	31. Date filed (Month, Day, Year)	38. Registrar's Signature	13 U. Hosp. In	=1 5. (Cour S	T Setter

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Joseph 4 2125 PM 27 Tuno /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) FEB 6, 1950 MARYLAND 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1X M 2□ F 212-56-9022 Director 55 Yrs. Usual Residence of Decedent the Maryland 10a. State 10b. County r then "neturel", or Items 23a or 28a-f show the Medical Examiner must be rediffed at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1100 63rd STREET Funeral 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

Inten 27 Is marked other then "neturel", or Itea iry or other treumetic event, it a Medical Examinat 1 Never Married & Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 WELDER AMTRAK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN BURKE, SR. CATHERINE SIMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERRI BURKE/ WIFE 1100 63rd STREET, BALTIMORE, MARYLAND 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State artment ortent: H * 4 □ Donation 5 □ Other (Specify) BAYVIEW CREMATORY 7/7/05 injury BALTIMORE, MARYLAND permit.
Departminitude Name and Address of Facility
ILLY & ZEILER INC. FUNERAL HOME
00 S. CONKLING STREET, BALTO., MD. 21. Signature of Funeral Service Licensee LILLY 700 S. The second second 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a los sequence of): Failure immediate /Medical Examiner Metastatic cancer mornins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed oral Luamou cell 2 years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? Completed 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1⊊Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending 1 Natural death. 2 Accident investigation 1 Yes 2 No Director: in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerel [To the Hospitel (s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-001 Susanna Mate M.D June 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE MAGILAND 21224 SUSANNA MATSEN 31. Date filed (Month, Day, Year) 62. Registrar's Signature State JUN 3 0 2005 Registrar

			State of Maryland / Depar	tment of Health and Nificate of Death	Mental Hygie	•	211.05
ı	Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	-	3. Time of Death
 ≯.	/Med		Robert Moylan Buckler, Sr.			Day Year 28, 2005	12:15 AM
1	Exami	ner		4b. City, Town, or Location of Death		4c. County of Dea	th
	F		10500 Rockville Pike, #313 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hrs.		Montgo	
	Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	ear) 9. Birt	thplace (State or Foreign ountry)
	PL _		Usual Residence of Decedent		October 17	, 1917 Was	shington, D.
	arylar ehow	_	10a. State 10b. County 10c. City, Town or Loca	tion			10d. Inside City Limits
	21215-0036 d within 72 hours after death with the Maryland jiene. r then "natural", or Itams 23e or 28e-f ehow the Madical Examinational be notilized at	ecto	Maryland Montgomery Rockvill				1 ☐ Yes 21☑ No
	with t	늅	105.00 Page 1-11 Pt 1 // 0.10	10f. Zip Code	10g.	. Citizen of What Co	ountry?
	leath	Funeral Director	10500 Rockville Pike, #313 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	20852		United St	
ထ	or Itan	Ξ	Armed Forces?	s Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
8	ral', c	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 ☐	Yes 2⊠ No Specify:		Specify: W	Mhite
Maryland 21215-0036	72 h 'natu	Completed	15. Decedent's Education 16a. Deceden (Specify only highest grade completed) (Give kin	nt's Usual Occupation	ing 16t	o. Kind of Business/	Industry
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Ž	is 1 and 2 of Health a itam 27 is other trace	1		ockville Pike #313			
ore,	of He of He litam	1 2	20a. Method of Disposition 20b. Place of Disposition	on (Name of	Date 20c	Location - City or	
Ĕ	Page ment ant: It	1	1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Glenwood C	emetery June	30, 05	Washingto	n. D.C.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic en one.		21. Signature of Funeral Service Ucensee M01420 Rob 755.	ame and Address of Facility ert A. Pumphrey Fun 7 Wisconsin Avenue,			
8760, <	Physician and physician and physician and physician sthe purial-transit	dicai Examiner	23a. Part . Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	he mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death YEAR IN STREET IN THE STREET IN THE STREET IN THE STREET IN THE STREET IN THE STREET IN THE STREET IN THE STREET IN THE STREET IN THE STREET IN THE STREET IN THE STREET IN T
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rds, F	w requires that been signed should be det	by	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		o use contribute to t	the cause of death?
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<u> </u>	yaician: is certifica director,	OB	examiner?	26. Place of Death Other: 4 \(\triangle \text{ Nursing Hor} \)		2 Flore - /2	
Division of	inding Phath.	ation; T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred	<u>(y)</u>
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	To the Hospital or within 24 hours after To the Funerel Dira completely filled in b	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occ of the death o	curred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as s nd place, and due to	stated. the cause(s)
,	To t To t Com,		Patricia Tomsko May, Md	29c. License number 05/9/6	290.0	Date signed (Month,	Day, Year) 2005
	54		Patricia Tomska May, MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Fatricia Tomsko Nay, IIII & Kockvil 31. Date filed (Month, Day, Year) JUN 3 0 2005	Ve Pike G-101	? Rocku	ille, MD	20852
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amend item#9,11,15,16a,17,18,19a-b,20a-c,22,perfn,6845,7,12,05 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month June Jerome Bright /Medical 4a. Facility Name (If not institution, give street and nymber) Examiner 4c. County of Death Maryland Greneral Hospi Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Dec 1, **Funeral** 9. Birthplace (State or Foreign Country) unk Days 1**∑**M 2□F Hours Min. Director 214-50-6439 56 Yrs. Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Yes 2□No MD 28a-f Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23¢ 827 Arlington Lane #611 Funeral 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian treumatic event, the Madical Examinar Black, White, etc. + Never Married 2 Married 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Be Completed by Specify: black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th unk Dental Tech 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle-Maiden Sumame) unk and Mental F be Shirley Bright Pages 1 and 2 should 2 Julian Bright Shirley B. Bright/ Mother 9b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1520 W. North Ave. Apt 206 Baltimore, MD 21217

827 Linden Avenue Baltimore, MD 21201 permit. Pages 1 and 2 : Department of Health ar Important: If item 27 Is eny injury or other treu once. Maryland General Hosptial 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State `4 □Donation 5 MOther (Specify) in state Arbutus Mem. Park 7/15/2005 Arbutus, MD 21. Signatur Uneral Service Licensee . Wad State And Address of Facily March West Ba 1300 Wabash Ave Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part shock Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death (ardiomy opathy Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): islon of Vital Records, P.O. Box 68760. by Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 Mo Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident М 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ro the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AmR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aryland Greneral Hospita Hirebranimi 31. Date filed (Month, Day, Year) State JUN 3 0 2005

Registrar

			1 - State	State of M	laryland / Depa			lental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle,	l ast)		rtificate of D	veatri	2. Date of Dea	Reg. N2 0 (15 2	21497
	Physic		Melvin Brandon	•				Month	Day	Year	→ Birmer br Lieath
>	/Medi Examii		4a. Facility Name (If not institution,		1	4b. City, Town, or I	ocation of Death	June 17	7 , 2005		8:03 AM M
1			Prince George'			Chever			Prince		co.t.c
	Funeral	Г	5. Social Security Number 6	. Sex 7. Ag	ge (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt	h		ce (State or Foreign
	Director		230-30-9385	1 ∑ M 2□F	73 Yrs.	World's Days	Hours Will.	Sept 9	, 1931	Country	w) unk
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				100	d. Inside City Limits
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	r 28e	rec	10e. Street and Number		Wasiii	10f. Zip Code			10g. Citizen of W	/hat Countr	
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	after death with the Marylan or Items 23a or 28e-f show miner is ust be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.1	Was Decedent of His	panic Origin? (Spe	cify Yes or No-		- American	
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Bal	permit. Page Department of Importent: If any injury or once.		2) Signatore of Funeral Service Lice Ronald S	Wade Dic	ctor St	Name and Address ate Anator ltimore, N	ny Board	655 W.	Baltimo	re St	reet
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	tificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
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687	tificate ig phy as the	edical		d							
Вох		m/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		F-4			23d. Date	of delivery	
B	that the death cer ed by the attendir detached for use	Physician/N	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐ Pregnant at		Ectopic pregnancy Other (specify)			Mont	h Da	y Year
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	To the Hospital or within 24 hours afte To the Funerel Dirt completely filled in the	edical	29a. Certifier 1 Certifying F	TIME OF THE PASIS OF	of my knowledge, death examination and/or invited	occurred at the time,	date and place, an	nd due to the ca	iuse(s) and mann	ner as stated	d.
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			30. Name and address of person who	completed course of d	asth (Itom 22a) T		1957		6	21-	05
			DR CARRY LITTLE	John Proced Cause of Ge	Bool Hosfit Ir's Signature	AZ DR	Pul	EVERIV	MD 21	018.5	
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	Funeral Director		5. Social Security Number 218-66-1487 Usual Residence of Decedent	1□M 2\\ F 99	Yrs. Months Days Hours		Date of Birth (Month, Day, Yea		thplace (State or Foreign ountry) unk
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939	within 72 hours after death ene. than "natural", or items 23 he Medical Examiner mus	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexico 1 Tyes 2 No Specify		fy Yes or No- can, etc.)	14. Race - Ame Black, Whi Specify: W	
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Maryland	should be filed vand Mental Hygie is marked other laumatic event, II	To Be C	17. Father's Name (First, Middle, Last		unk 18. Mot	her's Name (I	First, Middle, Maid	en Sumame)	unk
	and and is m		19a. Informant's Name/Relationship (Maryland Genera	•	19b. Mailing Address (Street and Number 827 Linden Aven				_
Baltimore,	Pages 1 nent of H ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☑ Other (Special	Removal from State	ce of Disposition (Name of netery, crematory or other place)	Dat	9 20c.	Location - City or	Town, State
Balt	permit. Pag Department Important: I any injury c snce.		21. Signature of Euroral Service Lice Ronald S.	Wade highwor	22. Name and Address of Factory Baltimore, MD	Board 21201	655 W. Ba	altimore	Street
68760,	Ex Medical Example of the butlat-transit the butlat-transit the butlat-transit the butlation of the butlatio	dical Examiner	23a. Part1 Enter the disease, or conshock, or heart failure. List only Immediate C. use (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ation nee of):	s cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 6	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3 Ectopic pregnancy			23d. Date of dei Month	ivery Day Year
	v requires that i been signed by should be deta		Part II. Other significant conditions of	contributing to death but not resulti	ng in the underlying cause given in Part			I tobacco use contribute to the cause of death? Yes 2 Who 3 Probably 4 Unkno	
al Reco	The ate his page	Completed by				_	24a. Was an autopsy performed? 1 Yes 2	prior to death?	atopsy findings available completion of cause of 2 No
Division of Vital Records,	ng Phy fter this ineral d	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	Other	Jursing Home	Check only one) 5 Residence I. Describe how inj		sify)
Divisi	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	281	Location (Street and City or Town, Sta		Iral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Pr (Check only one)	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the time, date an and/or investigation, in my opinion, de	nd place, and ath occurred	due to the cause(at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifier • DR • CHANCH	AL SINGH, M	29c. License number	795	37 Ju	Pate signed (Monti	7, Day, Year) 2005
			30 Name and address of person who		Ba) (Type, Print) / And C	1ene	ral Ho	Spita	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 3 0 20	32/Registrar's Signatur	Specific			1	

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Physician /Medical	1	ent's Name (Firs	B	B	ASS						2. Date of De Month	Day	Yes 20	05	ime of Death P
Examiner Funeral	No	Y Name (If not in RINWES Security Number	TH	DSPITA	7. Age (In yrs.	last birthday)	4b. Cily,	NPA	Location of	TOW	N M		County of D	TIM	DIFE State or Foreign
Director	23	7-50-96 sidence of Dece	16	□M 2ĂF	70		Months	Days	Hours	Min.	(Month, Da 4-5-1	v. Year)		RTH C	AROLINA
with the Maryle a or 28e-f shor			N/A			ALTIMO		Code				10a Citi:	zen of What	¥	ide City Limits]Yes 2 □ No
ter death villems 23	21 11. Marita	16 LORR				S. 13.	2	1207		gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	U	SA 14. Race - Ar Black, W	nerican Ind	ian,
Z1Z15-UU36 ad within 72 hours af gliene. er than "naturel", or st the Medical Exam Completed by F	3X∑V	/idowed 4 🗆 🗅	ivorced ecedent's Ed	If Yes, Giv Year or D	'e	16a. Dece	kind of wo	al Occupa	urina most	t of workin	og		Specify: B		· · · · · · · · · · · · · · · · · · ·
N POP	17. Fathe	r's Name (First,	Middle, Last)	College (1	-4or 5+)	COO	DO NOT u			r's Name	(First, Middle		OD SER	VICE	
Maryle d 2 should th and Mer th and Mer traumatic	19a. Info	LLIE KE] mant's Name/R THONY BA	elationship (19b. Mailir 2116	ng Address	(Street a	nd Numbe	or or Rural	OFTON Route Number	er, City or	Town, State	. Zip Code) 2120	7
Datrimore, IV permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr.	1 🖾		nation 3 <u>X</u> Other (Specify		State CAR	lace of Dispo emetery, cren VER ME HIBNER	sition (Nar. natory or o MORIA Name an	ne of ther place LPA d Addres	RK 7	Da 7 – 2–2 yPHIL	005 I	20c. Loc MT。 (UNERA	Cation - City of CLIVE,	NORT:	ate H CAROL A.
Physician	Immedia disease	11. Enter the disc ck, drieart failu de Cause (Final procondition	ease, or com re. List only	one cause on e	ach line.								RE, MA	Appro	D 21217 ximate al Between and Death
cate be executed physicien and the burial-transit clied burial-transit clied Examiner dical Examiner	Sequenti if any, lea cause. E Cause (D that initia resulting	in death) ally list condition ding to immedia ner Underlying isease or injury ed events n death) Last	s, te	b. Due to (c. Due to (d.	or as a consequence or a consequence o	uence of): uence of):	liac	cv-	tery	an	eny:	m			
The law requires that the death certifics. The law requires that the death certifics to has been signed by the attending proage 2 should be detached for use as the completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 growths? 1									2:	23d. Date of delivery Month Day Year		Year		
w requires that been signed b should be deta	rait ii. Ot	har significant o	conditions o	ontributing to de	ath but not resu	ulting in the un	nderlying ca	ause give	n in Part I.			obacco us	e contribute] No 3 □ I		e of death?
											129 Yes	sy rmed? 2 \(\sum \text{No} \)	24b. Were a prior to death? 1 X Ye	completion	lings available to of cause of
After fune	exam	es 2 No er of Death	-	28a. Date of		ER/Outpatient 28b. Time of Injury		A Other Bc. Injury Work	4 🗌 Nur	sing Hom	(Cifeck only o e 5 ☐ Resid 3d. Describe h	lence 6		ecify)	
To the Hospital or Attending P within 24 hours alter death to the Funeral Director: After t completely filled in by the tunera Medical Certification:		uicide 6 🗔 Iomicide	Could not be determined	28e. Place buildir	of Injury - At ho)		, office		28	Bf. Location (S City or Tow	m, State)			Number,
To the Hospital or within 24 hours afte to the Funeral Dir completely filled in Medical Cert	29a. Cert (Che one 29b. Sign	CA 01/19 2 11/19	A COLOR EXAM	rsician: To the iner: On the ba and mann	sis of examinat	vledge, death ion and/or inv	estigation,	in my opi	nion, deati	l place, an	d at the time, o	date and p	place, and du	is stated. ie to the car	
/	1	and address of	Nal	completed cause	of death (Item	23a) (Type, F		1	539	10		0	6/26	, 05	/
5 State	A .	MAHESH	WAR.	I,MD	NORTH I	NOT	HOS	PMA	1,	PAN	MALL	570	WN,	MD	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Sadie 24 12:35 A M June 2005 Collins /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2**X** F Yrs. Director 215-28-9098 ۷Á Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State itam 27 is markad other than "netural", or itams 23e or 28e-f ahow other traumatic avant, the Medical Evaniner must be rivillied at 10b. County 10d. Inside City Limits Director 1XYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 427 Oxford Court 21201 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "netural", or Itam any injury or other traumain. 1 Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: XXWidowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Nurse Assistant Red Cross 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Thomas Taylor Mamie Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patricia James-Daughter</u> 2629 Gatehouse Drive, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 6/30/05 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemin Physician esentevic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 honths?
1 Yes 2 No Month Day Year 4 Pregnant at time of death P.O. I signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has l autopsy certificate 1 Yes 25 or Attanding Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ipital: 1 Inpatient 2 28a. Dire of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Hospital within 24 hours a

To the Funaral I

completely filled filled Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) UMP18750 who completed cause of death (Item 23a) (Type, Print) e and address of person MP Union Memorial Hospital Baltimore MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar JUN 3 0 2005